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ABSTRACT

Beginning in 1963, concerned people in the city of Baltimore began to hold workshops and seminars dealing with the problems of alcoholism. Their main emphasis was on an educational program which would make accurate information about alcoholism and its treatment available to the general public. This led to a National Institute of Mental Health grant to develop an intensive program for training of non-professional persons interested in becoming alcoholism counselors in the various settings throughout the community where this problem is encountered. This handbook is a compilation of lectures and experiences designed to help such non-professional counselors; much of the information it contains would also be useful for trained professionals. In addition to extensive background information about causes, symptoms, methods of treatment, and resources, there are special sections on the family, the clergy, the law, industry, and teenagers. The handbook considers both alcohol as a "thing" and alcoholism as a process, related to family and community. (Author/BP)

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ED145296

HANDBOOK

for the

ALCOHOLISM COUNSELOR

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Alcoholism Center
Baltimore City Health Department
Baltimore, Maryland
Robert E. Farber, M.D., M.P.H.
Commissioner

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PREFACE

The Baltimore City Health Department's Alcoholism Clinic was established in 1963 through the untiring efforts of a small group of interested community leaders and public officials, and a handful of dedicated workers. At the time, the community climate was not very propitious and was well described in the Report of the Maryland Commission on Alcoholism of February 10, 1961.

The report stressed three major problem areas: (1) lack of trained personnel in the field of alcoholism, (2) lack of coordination and liaison between agencies treating or serving alcoholics, and (3) the reluctance among general hospitals to admit or treat the alcoholic patient.

Needless to say, these problem areas were obstacles to be overcome. Working on the hypothesis that the common denominator in the three problem areas was a lack of adequate information about alcoholism and the treatment thereof, an educational program seemed to be the most logical approach to the problem. Following are highlights of our attempts in that direction in Baltimore.

A Community Advisory Board, composed of executive representatives of community agencies was established; one of the major functions of the Board was to disseminate in their respective agencies factual information about the Clinic and its functions and above all, about alcoholism.

With the cooperation of the American Academy of General Practice, Baltimore Area Council on Alcoholism, Maryland Psychiatric Society, the Medical and Chirurgical Faculty of the State of Maryland and the State Department of Health and Mental Hygiene, a series of four seminars for physicians were held in 1964, on the diagnosis and treatment of alcoholism in industry and in private practice.

During the year 1965-1966, a series of seven seminars were conducted for the workers of the Department of Welfare. This series was sponsored jointly by Baltimore Area Council on Alcoholism, Baltimore City Department of Public Welfare, Baltimore City Health Department and the State Department of Mental Hygiene.

A one-day seminar for clergymen was conducted under the sponsorship of the Council of Churches for Maryland and Delaware, the Baltimore Area Council on Alcoholism, the Baltimore City Health Department and the State Department of Mental Hygiene.

A series of seminars based on case presentations, was held on alternate weeks throughout 1965-1966, and was attended by workers from social agencies, Public Health Nurses, student nurses and members of the Instructive Visiting Nurses Association.

The same handful of dedicated workers has been active in television appearances, radio programs, talks throughout the community to schools and clubs to acquaint the public with the problems of alcoholism.

These educational programs seemed very valuable in increasing public and professional awareness of the problems connected with the pathological use of alcohol but provided little relief in the three problem areas cited in the Report of the Maryland Commission on Alcoholism. Following the historic court decisions of 1965/1966 (Driver and Easter cases) there was a rapidly increasing demand for services for alcoholic patients which brought into sharp focus the need for trained personnel in the field of alcoholism.

Baltimore was not alone in this dilemma and something had to be done. The National Institute of Mental Health approved our proposed project "to develop an intensive program for training of non-professional persons interested in becoming alcoholism counselors in the various settings throughout the community where this problem is encountered."

Our Training Program for Alcoholism Counselors was started September 25, 1967. Todate, seventy-five trainees have completed the six-month program and have received our Certificate of Completion. They are presently working in the field of alcoholism and have been instrumental in the development of alcoholism programs in areas hitherto barred to the alcoholic patient.

Many colleagues and friends have helped in making this project a successful reality. We are deeply indebted to our advisors, consultants and lecturers for giving of their time and knowledge, and to our trainees for giving of themselves and their experiences. From these sources, we learned invaluable information.

Our indebtedness is further enhanced by the many meaningful contacts we have made and experiences we have shared.

This "Handbook for the Alcoholism Counselor" is a compilation of lectures and experiences and is designed as a road map covering most of the terrain the counselor is likely to encounter in his work.

No attempt has been made to include every contour line, bypass and historical marker along the way. Rather, it is a digest of information about relevant areas, surveyed and summarized for quick review.

Each area is identified by its chapter heading, as listed in the Table of Contents. For the counselor who may wish to explore a particular area in greater depth -- e.g., to participate in a seminar or address a group with specialized interests -- there is a list of supplemental reading at the end of each chapter citing informative material on the subject. (National Council on Alcoholism pamphlets and reprints can be obtained at local Council affiliates or from NCA Headquarters at 2 Park Avenue, New York, New York, 10016.)

Where appropriate, space has been provided for the counselor to write in the names and addresses of local resources to whom he may turn for information or cooperation. These are indicated in the Table of Contents. In Chapter IV, "Referrals and Resources," are found at the end of each section.

We sincerely hope that this Handbook will serve as an "open sesame" toward greater knowledge concerning the alcoholic, alcohol and alcoholism, for all who might use it.

A. M. Schneidmuhl, M.D.
Gladys L. Augustus
Robert B. Schall

Baltimore
November, 1970

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INTRODUCTION

One definition of public health is that it is that specialty of medicine which has the responsibility for putting the discoveries of the laboratory and consulting room to work for the preservation and restoration of the health of all the people. The possibility of doing this is found to be far beyond the capacity of the doctor and his traditional helpers. The job demands a far larger group of people who know and can do various parts of the job. Teaching these people who can make programs effective is one of the major educational challenges of the day.

Education in the past has generally been of three types. First, the "impractical" sort of education designed to make the thought and emotional life richer and more satisfying to help supply the material for "an abundant life." Secondly, there was the education about the physical world, its laws and materials and how they could be used. This is the education which results in the production of things, bridges, automobiles, buildings and airplanes. Thirdly, there is education which helps people serve and care for other people who need care and guidance. Traditionally, this is professional education-medicine, psychology, social work, nursing, law, and, increasingly, sociology and anthropology. It includes education in management and administration as well, since these also must reach their goals through dealings with people personalities.

It is this third type of education that has been brought very forcibly to the fore by the recognition for the need for expanded medical manpower who can influence people rather than do things to them.

This Handbook is a reference book for the new type of manpower which is inheriting many tasks previously reserved for people with long and thorough professional education. To educate people to do tasks that these others have done requires new methods and careful consideration of what can be left out in the educational process without running unacceptable risks with the lives of people to be served. The Handbook aims to buttress previous classroom and human laboratory (field) training with a reference volume which will keep principles fresh and available, to maintain the level achieved at the end of the training period.

Its content is of two types: first about alcohol and the ways the drug is used and misused. This is factual information. Secondly, the Handbook deals with the problem of how to work with people, alcoholics and their families, to alleviate the medical and social problems of the community as they are related to alcohol. The Handbook deals with a "thing," alcohol, and a process, helping the alcoholic and his family and those in the community who are responsible for their care and management. The first job is relatively easy and has been done often before. The second task has been more of an adventure and I suspect it will stand up as a second tactical tool to put the present state of knowledge to work for the promotion of health and the protection of the health of that part of the population threatened by the disease of alcoholism.

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CHAPTER I

ALCOHOL AND ALCOHOLISM

"We deal with alcohol -- cunning, baffling, powerful," says the "Big Book" of Alcoholics Anonymous.

So be it. But the cunning, bafflement and power have often been embellished by those who exploit it for their own ends. "Grab for all the gusto you can get!" urges the beer advertisement. "There's death in the cup -- so beware!" warns the teetotalist.

As a result, so many prejudices and old wives tales have been fostered by alcohol and alcoholism that John Doe has found himself groping in a fog of misunderstanding.

The alcoholism counselor, if he is to function effectively, must cut through the smoke screens and camouflage. Only in that way can he distinguish the true from the false and win the confidence of his patients, their families and their associates. And once he feels reasonably informed, there will be new facts and findings to assimilate and adapt to as research keeps marching on.

ALCOHOL, THE BEVERAGE

The history of man's use of alcohol may be boiled down to two sentences. Historically, there is every evidence that man learned how to brew beer before he learned how to bake bread. So we have had alcohol, the beverage, with us through the ages and will probably continue to have it to the end of time -- legislation and condemnation notwithstanding.

The alcohol contained in the beverage alcohol is called ethyl alcohol (C_2H_5OH), also known as ethanol. There are many other types of alcohol -- such as methyl or wood alcohol, isopropyl or rubbing alcohol, both unfit for human consumption.

First, to examine some popular misconceptions:

Alcohol is *not* a stimulant. On the contrary, it is an anesthetic. As explained in the next section, it puts judgment and inhibitions to sleep so that emotions and desires are allowed to function unrestrained, giving a false sense of stimulation.

Alcohol is *not* an aphrodisiac, it does not stimulate one's appetite for sex. Although one or two drinks may lower the individual's inhibitions and facilitate the expression of repressed sexual desires, in larger amounts alcohol -- being an anesthetic -- tends to curb sexual desire and, in the male, may even impair his ability to perform.

Alcohol is an addictive drug. As with all other addictive drugs, the excessive use of alcohol leads to an increased tolerance for it. In the early stages of the disease, the alcoholic can consume much more than the non-alcoholic. Also, withdrawal symptoms often occur with abstinence. One of the more widely known examples is delirium tremens. However, it must be stressed that, as with all other addictive drugs, not all users become addicted. In the case of alcohol, only about 6 to 7 per cent of all drinkers become alcoholics.

Alcohol does not necessarily stimulate one's appetite for food. As a sedative, alcohol taken in small quantity before a meal may help one "unwind" and thus add to his enjoyment of the food by temporarily alleviating his emotional frustrations and worries. Some drinks (aperitifs) contain substances (strychnine, quinine, etc.) specifically for the appetite stimulating effects. In larger amounts, it suppresses the appetite, because one ounce of alcohol supplies 200 calories to the body. As a result, a heavy drinker may forego meals and rely on alcohol for his needed energy. But alcohol is a very poor substitute for food since it does not supply the proteins, vitamins and minerals necessary to good health.

Drinking in moderation does not in itself cause disease. But prolonged, excessive use of alcohol may lead to illnesses in several ways. They can be the direct result of the toxic effects of the drug on living tissue -- e.g., fatty deposits in the liver, heart muscle, etc. They can be the result of poor nutrition -- the lack of proteins, vitamins and minerals mentioned above. Or they can be the result of lowered resistance to infectious diseases -- i.e., the inhibition of the antibody building, defense mechanisms of the body.

By itself, alcohol is not a killer. It is virtually impossible for a man to deliberately "drink himself to death." When the concentration of alcohol in the blood reaches .50 per cent, it affects the portion of the brain that controls breathing and heartbeat, and death follows. But the drinker loses consciousness when the concentration reaches .40 per cent, at which point he can drink no more.

There is no alcoholic "drink of moderation." Beer, wine, and spirits all contain alcohol. It may take more beer (4%) than 100 proof whiskey (50%) to reach the same state of intoxication. But the effect of the alcohol is the same. The "moderation" rests in the drinker.

PHYSIOLOGICAL EFFECTS

When one takes a drink -- be it man or woman, alcoholic or non-alcoholic -- the brain and body respond in a systematic manner.

About 10 per cent of the alcohol is eliminated through the lungs, kidneys and pores of the skin. The remaining 90 per cent is directly absorbed into the blood stream through the walls of the stomach and small intestine. No other digestive processes are involved.

Once in the blood stream, it is distributed to the body tissues.

En route, the alcohol passes through the liver, where it is oxidized and transformed into energy. But even a healthy liver can only oxidize about three-quarters of an ounce per hour. So the excess accumulates in the blood and continues to circulate.

In the blood, alcohol reaches the brain. Here it has a sedative and an anesthetic effect.

The first part of the brain to be affected is the frontal lobe of the cerebrum. This is the seat of reasoning, conscious thinking, memory, self-control. As the frontal lobe is gradually anesthetized by the alcohol, inhibitions disappear. The man forgets his limitations and becomes Mr. Big. No transient ambition is beyond his capacities. The anxieties of day-to-day living evaporate and the world is his friend. This is the false "stimulation" referred to before.

As the concentration of alcohol in the blood increases, other areas of the brain are affected. The motor area of the cerebrum and the cerebellum control motor activity, muscular coordination and equilibrium. The drinker becomes clumsy and he begins to have trouble walking and keeping his balance. The speech, hearing and vision centers of the brain become affected, which result in slurred speech, dulled hearing and blurred vision. When the sensory area is affected the drinker "feels no pain," thus being deprived of a frequently lifesaving alarm system.

Finally, the medulla -- the portion of the brain connected to the spinal cord -- is affected. This is responsible for the vital functions of the body, including heartbeat, blood flow and breathing. Depending upon the concentration of the alcohol, the drinker will lose consciousness, go into shock, or die.

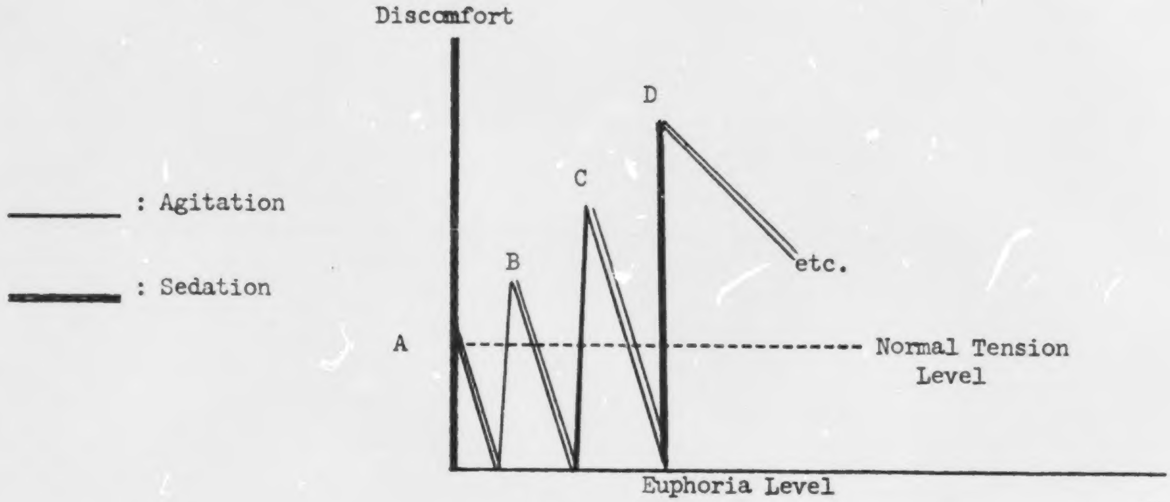
Thus a drinker's behavior and capabilities are directly related to the alcoholic concentration in his bloodstream. Such being the case, the drinking "capacity" of one man can vary from that of the next. The body fluids inside a 250-pound mailroom clerk. Other things being equal, more alcohol is required to raise the football player's concentration to .40% or to any other given degree. So the amount of liquor considered "excessive" for one man may not be "excessive" for the next.

But football player or mailroom clerk, a drinker's behavior pattern generally conforms to the following levels of concentration:

.06%	Feeling of warmth, relaxation, less concern with minor irritations.
.09%	Buoyancy, exaggerated emotion and behavior, talkative or morose.
.12%	Impairment of fine coordination, slight to moderate unsteadiness in standing or walking.
.15%	Legal point of intoxication, abnormality of gross bodily function and mental facilities.
.30%	Stupor
.40%	Unconsciousness, possible state of shock.
.50%	Death

There are, of course, other physiological effects resulting from drinking, many of which are noted below, under "Progressive Symptoms."

Both alcoholics and non-alcoholics, however, are liable to suffer irritation of the throat, esophagus and stomach lining through excessive drinking of undiluted liquors. Painful alcoholic gastritis can result from the latter



"HANGOVERS"

Then there is that transient hell through which any drinker can pass after he has imbibed too much -- "the hangover."

All sedatives, including alcohol, have a double-barreled effect. One is the tranquilizing effect which causes men and women to drink. The other is an irritating effect resulting in "psychomotor hyperactivity" which lasts many hours longer and which accounts for the "morning after" distress.

In the accompanying schematic diagram, assume that a man on his way to a party is somewhat nervous and normally anxious (point "A"). He takes a stiff drink to alleviate his anxiety and induce a sense of euphoria. At this stage the sedative effect of the alcohol is intense enough to mask the agitating effect. But within a relatively short period of time, the sedative effect of the alcohol is gone and he is left with only the psychomotor agitation, which gradually accelerates to point "B." He decides upon another drink to rectify matters. Now he needs even more sedation -- first, to get back to his normal state, and then more to become euphoric again. So the process of alternating sedation and agitation continues to points "C," "D" and so on -- until he either goes to bed himself or is carried there by his friends.

In actuality, the party-goer would surely refuel at the first suspicion that his euphoria was wearing off. But he would still awaken the following morning with an accumulation of the agitating effects of his drinks, which last about twelve hours from the time of imbibing. He has three choices: to sweat them out; to take a milder sedative to allay some of the pain; or to have some "hair of the dog that bit him." The last is rather dangerous. He might find himself back on the same merry-go-round again.

ALCOHOLISM DEFINED

Thus far everything has applied to all the men and women who drink any alcoholic beverages at all.

What about the alcoholic? What about the 6 to 7 per cent of those drinkers -- the 1 out of 14 or 15 -- who have lost control of their drinking? What distinguishes them from the others?

There are hundreds of definitions of alcoholism. The technical one published by the World Health Organization reads as follows:

"Any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior, and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physio-pathological and metabolic influences."

Shorter descriptions of the alcoholic include:

"One who repeatedly seeks to change reality through the use of alcohol."

Or

"One who suffers because of uncontrolled compulsive drinking."

For the alcoholism counselor, the following definition may serve as a useful yardstick in evaluating a client's status:

"An alcoholic is one whose drinking interferes with his health, his job, his relations with his family, or his community relationships -- and yet he continues to drink."

The interference need only be felt in one of the above areas of living for a person's classification as an alcoholic.

The fact that the alcoholic "continues to drink" implies loss of control, which is a characteristic of the illness.

The definition applies to men and women alike. Although it was once thought that male alcoholics outnumbered female alcoholics about five to one, it is now agreed that the number of women is much closer to that of men. Many private physicians who treat both men and women alcoholics say the ratio is about fifty-fifty.

And the definition applies to all social and economic "classes." Only 3 per cent of the alcoholics in the United States are found on Skid Row. The other 97 per cent stretch from waterfront saloons to Main Street and the Hall of Congress.

ALCOHOLISM: TYPES

Since the alcoholic is usually the last to recognize his illness, he often challenges the doctor or counselor with:

"I only drink weekends (or paydays)!" or

"I can go months without touching a drop!" etc.

Such protests may be true. Nevertheless, he can still fall into one of the classifications of alcoholics that have been arrived at by many specialists in the field.

Probably the best known classification is that of the late Dr. E. M. Jellinek, former consultant to the World Health Organization. He identified various types of alcoholics with Greek letters:

Alpha: This man or woman relies upon the effect of alcohol to boost morale, bolster self-confidence or relieve emotional pain. He might be regarded as a "social drinker" except for the fact that he often drinks too much at the wrong times, among the wrong people, and is thereby apt to affront others.

The Alpha type does not lose control and can abstain when necessary. However, his drinking can give rise to family squabbles, occasional absenteeism from work, and be a drain on the family budget.

Alpha drinkers may develop into full-fledged Gamma alcoholics (see below). Hence, they are considered by many to be "pre-alcoholics," and should be treated accordingly to forestall that possibility.

Beta: This alcoholic gets sick. He does not become addicted and he suffers no withdrawal symptoms if he stops in time.

But his poor nutritional habits -- i.e., substituting alcohol for necessary proteins, minerals and vitamins -- lead to such medical complications as peripheral neuritis, cirrhosis of the liver and gastritis. When hospitalized his ailments are all too often treated without regard to the drinking habits that have caused them.

Gamma: These are the alcoholics who most frequently need help from alcoholism clinics and such organizations as Alcoholics Anonymous. Their psychological dependence upon alcohol has grown into a physical dependence. They have lost control over their drinking, and they suffer withdrawal symptoms when they abstain. In early and middle stages of the illness, their tolerance for alcohol is much greater than that of the non-alcoholic. But in late stages their tolerance abruptly decreases to the point where even a single drink can make them ill. (See "Tolerance" and "Progressive Symptoms," below.)

Delta: The Delta alcoholic maintains a steady concentration of alcohol in his bloodstream during his waking hours. Usually he has grown up where alcohol is an all-purpose beverage, served at all meals. But he can be a business executive whose eye openers and three-martinis-for-lunch have become a ritual, or "the little old lady" whose daily quota of dry sherry is a must. Seldom visibly intoxicated, the Delta alcoholic will suffer withdrawal symptoms when forced to abstain. For example, when hospitalized for several days prior to surgery, they may develop delerium tremens.

Epsilon: This is the so called binge drinker, who will go for a long period -- weeks, months, or even a year -- without a drink. But once he starts, it is explosive. He continues drinking until he goes into a stupor. If the binges continue with increasing frequency, he may become a Gamma alcoholic.

Dr. Jellinek wrote that there are many other types of alcoholism, more than there are letters in the Greek alphabet. But the above five are the ones the alcoholism counselor is most likely to encounter.

Despite the protests of many alcoholics -- particularly the Gammas, Deltas, and Epsilons -- that they "can take it or leave it" or "only drink on payday," there is one common denominator. Consciously or subconsciously, they are forever looking forward and planning for the next drink, be it tomorrow, next week, or six months from now. This is not conducive to the "comfortable sobriety" that leads to recovery.

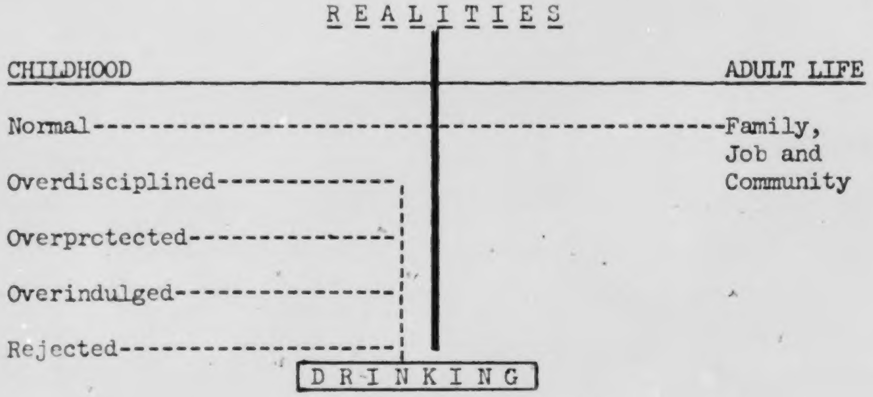
CAUSES OF ALCOHOLISM

Those engaged in scientific research have yet to establish that there is any hereditary influence in a person's susceptibility to alcohol addiction.

Nor is there any physical basis for alcoholism. However, as already noted, there can be a growing physiological dependence upon alcohol as the disease progresses.

Psychological and personality factors play an important role.

While heredity apparently has no part in determining the possibilities of a youngster's becoming an alcoholic in later years, his environment can. Many surveys indicate that about half the adult alcoholics interviewed have at least one alcoholic parent. Other children may be so repelled by the ugly topsyturvydom of parental drinking that they go through life without touching a drop -- although they may suffer other emotionally crippling effects.



CHILDHOOD EXPERIENCES

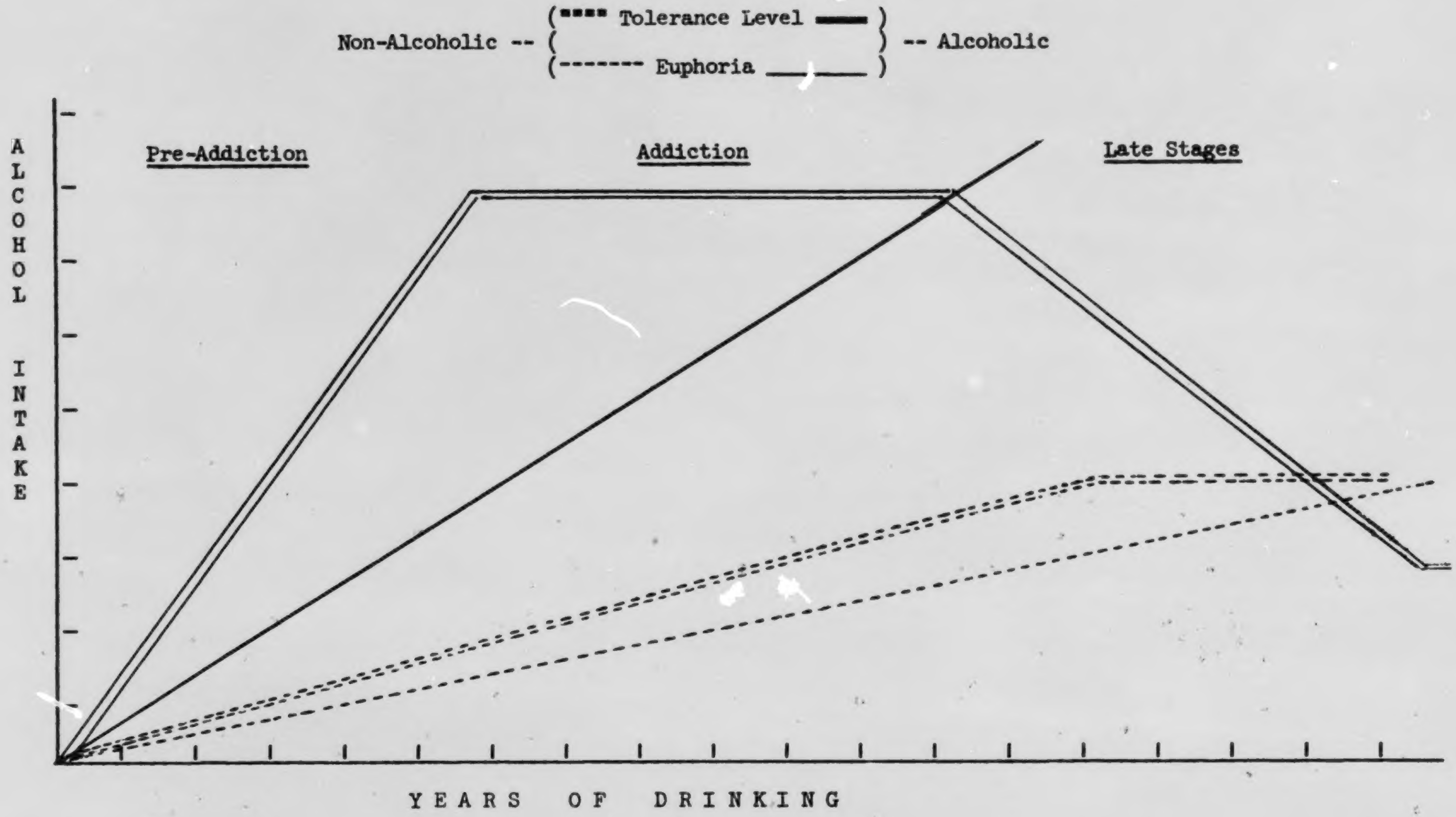
More important is the manner in which the child is taught to face reality. As the accompanying "Childhood Experiences" chart indicates, the "normal" child with "normal" parents sees them tackle the problems and decisions in everyday living as they arise. Other things being equal, he will do the same with his lesser difficulties and continue to do so with the big ones in adulthood.

But if the parents overdiscipline, overprotect or overindulge him, he will be more apt to shy away when confronted by any situation that demands his decision or constructive action. Later in life, he discovers that alcohol offers him temporary escape. This discovery eventually leads into habit. As he takes flight in the bottle more and more often, he can develop such a physiological dependency upon it that he is well on the way to full-fledged alcoholism.

The same liability faces the rejected child. Knowing he is not wanted, he is bound to feel a sense of inadequacy. Unless that is overcome, his so called solution to his problems may eventually be the same.

Of course, all alcoholics did not start out in life as overdisciplined, overprotected, overindulged or rejected children. The death of a loved one,

ALCOHOLIC AND NON-ALCOHOLIC TOLERANCE CURVES



unavoidable hard times, another's disloyalty, incessant physical pain, etc., can provoke feelings of inadequacy or frustration at any time from the nursery to the grave. When a person repeatedly turns to alcohol as an escape from his anxieties, great or small, he becomes a potential alcoholic.

In short, the onset of alcoholism is not determined by how much a man drinks, but why he drinks.

TOLERANCE

Once embarked, the alcoholic's course is irreversibly charted -- unless he turns to total abstinence at some point along the way. In that case, he can arrest the progress of his illness. He cannot turn back. He cannot retrim his sails for social drinking.

The accompanying diagram of "Alcoholic and Non-Alcoholic Tolerance" indicates the general course the illness takes.

The "alcohol intake" level refers to the amount consumed at any one occasion. As noted above, what is excessive intake for one person is not necessarily excessive for the next. Among other things, it varies according to the physique of the individual.

The "years of drinking" are also relative. The time it takes a novice drinker to become an addict can be anywhere from one to twenty years.

The "euphoria level" is the point at which the drinker reaches Cloud Nine, forgets his inhibitions, and revels in his own fancied charm as well as that of others.

The "tolerance level" is the point at which he gets sick and can drink no more.

Both the alcoholic and non-alcoholic start their drinking histories with one thing in common -- it takes little alcohol to put them in high spirits and little more to make them sick.

As time passes, both require more alcohol to reach either level. But the alcoholic needs more and more. Because of the greater significance he gives to drinking, during pre-alcoholism years he may learn how to space his drinks and to some extent control his behavior. But he cannot manipulate his tolerance level. That is biologically determined.

There comes the time when the alcoholic's tolerance levels off. This is usually marked by a loss of control -- give him one drink and he is "off to the races." He has become addicted, physiologically dependent upon alcohol. From this point on, he continues to need more and more to escape everyday reality and regain a sense of euphoria. But his "capacity" before getting sick remains the same. As a result he can handle fewer and fewer drinks after he begins to feel carefree. But he cannot stop in that desirable state of bliss. He is compelled to keep drinking until he is physically unable to drink anymore.

Eventually there comes the day when he drinks just as much, but feels no sense of well-being at all. He only gets sick. (This is the point on the diagram where the tolerance and euphoria lines meet.) Desperately, he goes on benders in search of the alcoholic euphoria he is never to know again. He continues drinking, but gets sick sooner because his tolerance level is plunging down. He discovers that he cannot even keep up with the non-alcoholic friends whom he used to drink under the table any day in the week. One unproductive drink, maybe two, and he is through. His brain and the rest of the body have taken all the alcoholic abuse they can.

PROGRESSIVE SYMPTOMS

The behavioral characteristics of the alcoholic are as progressive as his tolerance to alcohol and the course of the disease itself. They often enable the counselor to determine the relative status of a patient's addiction.

An inventory of some of those symptoms follows. They are not necessarily in precise chronological order. Some may never be experienced by an individual alcoholic. But most of them are experienced and, in toto, are mileposts along the way.

PRE-ADDICTION:

The road to alcoholism begins when drinking is no longer social but a means of psychological escape from the tensions and inhibitions. Although the eventual problem drinker is still in reasonable control, his habits begin to fall into a definite pattern:

1. Gross drinking behavior: He begins to drink more heavily and more often than his friends. "Getting tight" becomes a habit. When drunk, he may develop a "big shot" complex, recklessly spending money, boasting of real and fancied accomplishments, etc.

2. Blackouts: A "blackout," temporary loss of memory, is not to be confused with "pass-out," loss of consciousness. The drinker suffering from a blackout cannot remember things he said, things he did, places he visited while carousing the night before -- or for longer periods. Even a social drinker can have a blackout. With prospective alcoholics, they are more frequent and develop into a pattern.

3. Gulping and sneaking drinks: Anxious to maintain a euphoric level, he begins to toss off drinks at parties and slyly gulp down extra ones when he thinks nobody is looking. He may also "fortify himself" before going to a party to insure his euphoria. He feels guilty about this behavior and skittishly avoids talking about drinks or drinking.

4. Chronic hangovers: As he grows more and more reliant on alcohol as a shock absorber to daily living, "morning after" hangovers become more frequent and increasingly painful. (See "Physiological Effects," above.)

ADDICTION:

Until now the problem drinker has been imbibing heavily but not always conspicuously. More important, he has been able to stop drinking when he so chose. Beyond this point, he develops the symptoms of addiction with increased rapidity:

5. Loss of control: This is the most common symptom that a drinker's psychological habit has become an addiction. He still may refuse to accept a drink. But once he takes a drink, he cannot stop. A single drink is likely to trigger a chain reaction that will continue without a break into a state of complete intoxication.

6. The alibi system: His loss of control induces feelings of guilt and shame. So he concocts an elaborate system of "reasons" for drinking -- "he just completed his income tax," "he failed to complete his income tax," etc. He hopes these will justify his behavior in the eyes of his family and associates. In reality, they are mostly to reassure himself.

7. Eye-openers: He needs a drink in the morning "to start the day right." His "morning" may start at any hour of day or night. So an eye-opener is in fact sedation to ease his jangled nerves, hangover, feelings of remorse, etc., after a period of involuntary abstinence, while he was asleep. He cannot face the upcoming hours without alcohol.

8. Changing the pattern: By now he is under pressure from his family, employer, or both. He tries to break the hold alcohol has on him. At first he may try changing brands -- e.g., from whiskey to beer. That does not good. Then he may set up his own rules on when he will drink and what he will drink -- e.g., only three martinis on weekends and, of course, holidays. He may even "go on the wagon" for a period. But one sip of alcohol and the chain reaction starts all over again.

9. Anti-social behavior: He prefer drinking alone or only with other alcoholics, regardless of their social level. He believes that only they can understand him. He broods over imagined wrongs inflicted by others outside this pale and thinks people are staring at him or talking about him. He is highly critical of others and may become violent or destructive.

10. Loss of friends and job: His continuing anti-social behavior causes his friends to avoid him. The aversion is now mutual. Members of his family may become so helplessly implicated that his wife leaves him -- "to bring him to his senses." The same situation develops between him, his employer and fellow workers. And so he loses his job.

11. Seeking medical aid: Physical and mental erosion caused by uncontrolled drinking leads him to make the rounds of hospitals, doctors, psychiatrists, etc. But because he will not admit the extent of his drinking, he seldom receives any lasting benefit. Even when he does halfway "level" with the doctors, he fails to cooperate in following their instructions and the result is the same.

LAST STAGES:

Until he has reached this point, the alcoholic has had a choice: to drink or not to drink -- that first drink. Once he began, he lost all control. But in the last stages of alcoholism, he has no choice at all. He must drink:

12. Benders: He gets blindly and helplessly drunk for days at a time, hopelessly searching for that feeling of alcoholic euphoria he once appreciated. He utterly disregards everything -- family, job, food, even shelter. These periodic flights into oblivion might be called "drinking to escape the problems caused by drinking."

13. Tremors: In the past his hands may have trembled a bit on "mornings after." But now he gets "the shakes" when he is forced to abstain, a serious nervous condition which racks his whole body. When combined with hallucinations, they are known as the D.T.'s (delerium tremens), often fatal if medical help is not close at hand. During and immediately after an attack, he will swear off liquor forever. He nevertheless comes back for more of the same.

14. Protecting the supply: Having an immediate supply of alcohol available becomes the most important thing in his life -- to avoid the shakes, if nothing else. He will spend his last cent and, if necessary, sell the coat off his back to get it. Then he hides his bottles so there will always be a drink close at hand when he needs it -- which can be any hour or minute of day or night.

15. Unreasonable resentments: He shows hostility to others. This can be a conscious effort to protect his precious liquor supply, be it a half-pint on the hip or a dozen quarts secreted about the home. It can also be outward evidence of an unconscious desire to punish himself.

16. Nameless fears and anxieties: He becomes constantly fearful of things he cannot pin down nor describe in words. It is a feeling of impending doom or destruction. This adds to his nervousness and further underscores the compulsion to drink. These fears frequently crop up in the form of hallucinations, both auditory and visual.

17. Collapse of the alibi system: He finally realizes that he can no longer make excuses nor put the blame on others. He has to admit that the fanciful "reasons" he has been fabricating to justify his drinking are preposterous to others and now ridiculous to himself. This may have occurred to him several times during the course of his alcoholic career. But this time it is final. He has to admit that he is licked; that his drinking is beyond his ability to control.

18. Surrender process: Now if ever, he must give up the idea of ever drinking again and be willing to seek and accept help.

If at this point the alcoholic is unable to surrender, all the signposts point to custodial care or death.

If he has not already suffered extensive and irreversible brain damage, there is a strong likelihood that some form of alcoholic psychosis will develop.

The amnesia and confabulation of Korsakoff's syndrome and the convulsions and comas of Wernicke's disease are possibilities.

Death may come in advanced cases of cirrhosis of the liver, pancreatitis, or hemorrhaging varices of the esophagus.

Or he may arrange his own death by suicide. After all, the suicide rate among alcoholics is three times the normal rate of self-extermination.

TREATMENT

There is as yet no cure for alcoholism.

The alcoholic is fortunate that the disease is treatable, that it can be arrested. But treatment is of no avail unless that addicted patient subscribes to total abstinence from drinking alcohol in any form. As pointed out above, once he has lost control, he will never regain it.

Also, the sooner the progress of the illness is recognized and arrested, the easier the return to a comfortable and contining sobriety and the less physical and mental deterioration.

The treatment of alcoholism falls into three overlapping lines of action designed for three overlapping objectives:

1. Emergency treatment: Immediate medication, etc., designed to avert physical disaster or even death.
2. Inpatient treatment: "Drying out." To alleviate the nervous and physical abnormalities resulting from prolonged and excessive drinking.
3. Follow-up treatment: Psychological rehabilitation necessary for continued sobriety.

Much of the data in the next two sections is for the alcoholism counselor's information only. The prescription and administration of medication and therapeutic procedures are the sole responsibility of authorized medical personnel. However, the counselor should be aware of general practices in order to help the patient and his family arrive at decisions.

EMERGENCY TREATMENT

Both acute alcoholic intoxication and many of the withdrawal symptoms which follow can call for prompt treatment in the emergency room of a general hospital.

However, before making a diagnosis of alcohol intoxication, the staff must rule out skull fracture, subdural or subarachnoid hemorrhage, cardio-vascular injury, and diabetic or insulin shock. These are quickly ascertained by laboratory and X-ray tests. Even though blood tests may indicate a high concentration of alcohol in the bloodstream, they do not veto the possibility that other factors may be the primary cause of his condition.

Once alcohol intoxication is diagnosed, it must be remembered that alcohol is in itself a powerful sedative. If the patient is in a stupor or in a comatose state, he should not be given any further sedation.

In cases where treatment for psychomotor agitation (e.g., "the shakes") is indicated, a tranquilizing drug such as Librium is highly effective in reducing tension. Many doctors feel that 100 mgs. given intramuscularly, then followed by smaller amounts taken orally every three or four hours for twelve to twenty-four hours, allow the body to adjust to the abrupt withdrawal of alcohol. Other tranquilizers such as Thorazine, Sparine, Mellaril, Vistaril, Atarax, etc. are equally effective. An old standby, paraldehyde, has been largely eclipsed by newer drugs because of its habituating properties. Narcotics and barbituates should definitely be avoided because of even more habituating properties. They can only add further addictions to the addiction which already exists.

More serious and sometimes fatal are alcoholic coma, convulsions, hallucinosis and delirium tremens.

Before making a diagnosis of alcoholic coma, the following conditions must be ruled out: skull fracture, subdural or subarachnoid hemorrhage (bleeding in the membranes surrounding the brain), cardio-vascular accident (heart attack), uremia, insulin shock and diabetic coma.

One of the main dangers in alcoholic coma is a respiratory failure, followed by circulatory collapse. It may be necessary to maintain adequate airway to the lungs, use artificial respiration, and/or administer stimulants to the central nervous system. Another danger is the inhalation of vomited matter, which can cause lung abscess or pneumonia. Possible fractures and lacerations resulting from falls must also be considered.

Alcoholic convulsions ("rum fits") closely resemble the grand mal seizures of epilepsy. The examining physician should make certain -- by electroencephalogram (EEG) if necessary -- that the patient is not suffering from the latter disorder. The primary concern is that he does not injure himself in falling or thrashing about, or by biting or swallowing his tongue, which can cause him to choke to death. A spoon, a leather belt or any device he cannot bite through should be inserted between his teeth. Valium is a useful drug in controlling the attack. To prevent such attacks, Dilantin, an anticonvulsant, is prescribed for alcoholics with a history of seizures.

Alcoholic hallucinosis usually occurs after a patient has been detoxified The hallucinations can be either auditory or visual, with the former more common. They are not as frightening as the fantastic figments encountered during D.T.'s and the patient is usually oriented as to time, place and the existing situation. There is danger of suicide and the patient should be watched.

Delirium tremens (D.T.'s) is a withdrawal symptom which can occur many days after the alcoholic has stopped drinking and, when not immediately treated, can be fatal. As the name implies, it combines visual and auditory hallucinations with extreme tremors and even grand mal type convulsions. Unlike alcoholic hallucinosis, the patient is completely disoriented. His hallucinations take the form of grotesque human and animal ghouls which threaten him from every side. He should be treated in a well lighted room because every shadow can conjure up another evil menace to panic him. An attending nurse, counselor or other aide should not argue about the existence of these phantasms -- only reassure the patient that nobody will harm him. Librium, Vistaril, chlorpromazines and other tranquilizers are used in treatment.

(The gravity of D.T.'s cannot be overemphasied. In a situation where a patient shows signs of impending D.T.'s and no medical help is available, he can be given an ounce or two of whiskey or fortified wine. This will help to stave off the attack until he can be handed over to a hospital emergency room.)

Coma, convulsions, hallucinosis and D.T.'s are definite medical emergencies and should be treated in the hospital until the patient has fully recovered from the immediate crisis.

In other cases of acute phases of chronic alcoholism, if the patient is not too ill he may be discharged in the care of a cooperative family or interested person who will follow medical instructions.

In any event, the patient must be directed to follow up his emergency room treatment by seeing his family doctor, coming back to the hospital's outpatient clinic, or arranging for continued treatment at a public or private alcoholism clinic. This is for his own protection as well as that of the hospital and personnel who attended him.

INPATIENT TREATMENT

Then there are the hundreds, even thousands of non-emergency patients whose prolonged and excessive drinking has left them so mentally and physically "run down" that they are incapable of adequately dealing with their responsibilities at home or on the job. Simply to let them sleep off their drunks or give them tranquilizers to cushion their shakes and then send them on their ways is inviting trouble. Most of them will wander into the nearest tavern or liquor store and promptly find themselves in worse trouble than they were before -- back again in "the revolving door."

What they need is "drying out," both physical and mental. They need to start repairing the damage the persistent drinking has done to their bodies. They need to disentangle their confused thinking before they can even grasp the meaning of any new program of rehabilitation.

For these persons the best solution is six to eight days hospitalization. In this way, constant care and medication is assured. If they suffer withdrawal symptoms -- such as hallucinosis or D.T.'s -- there is professional help at hand for immediate treatment, or even to avert the attacks. Above all, they are removed from the temptation of sneaking drinks that often undo the good of treatment at home.

Patients are usually kept on bed rest for the first twenty-four hours after admission, during which they are given routine laboratory and X-ray tests. There will be psychomotor agitation as the patient's body adjusts to the abrupt withdrawal of alcohol. Tranquilizers such as Librium, Sparine, Mellaril, Thorazine, Vistaril, or Atarax will keep him in a state of quiet suspense for the first 36 to 48 hours and are gradually tapered off as his condition improves.

At the same time steps are taken to correct the vitamin-mineral deficiency which has been building up over the days, weeks, or months the patient has been drinking instead of eating. He is put on a high protein diet and multivitamins. Orange juice, with a dash of sodium chloride in it, is kept at his bedside. And in cases of severe dehydration, he is given "Philadelphia cocktails" intravenously, which contain a glucose-saline solution, insuline, and vitamins.

As this period of rest and recuperation progresses, his thinking begins to straighten out. This is the time to lay the groundwork for follow-up treatment. He must be made to realize that recovery from chronic alcoholism is not an overnight or eight-day procedure. The damage has been years in the making. Even with his sincere cooperation, it takes one or two years to make basic psychological and physical repairs. This is the time to line him up for continuing treatment at an outpatient clinic, Alcoholics Anonymous, or other therapeutic agencies.

During this period, the patient may also be started on Antabuse (see "Deterrent Therapy," below).

FOLLOW-UP TREATMENT

The chronic alcoholic cannot stay sober without help. (One hears of the person who "did it on his own," but one seldom meets him in the flesh.)

The alcoholic needs support. He should have the encouragement of family and friends, if he has any left. But the support of family and friends can be erratic and is not to be found in some areas where he needs help the most.

He constantly needs to remember that he is an alcoholic who cannot afford to take a drink without unfortunate results -- just as the diabetic cannot afford to forget his ailment and his insulin, or the epileptic his Dilantin.

For years the alcoholic has been committing physical and mental hara-kiri and he may need prolonged medical or psychiatric help.

Alcoholism can be expensive; and, therefore, the patient may be broke. Alcoholism loses jobs; he may need employment. Alcoholism causes dissension; he may seek reconciliation with his family. And so on.

Unless he is spiritually barren, he can be kept reminded of his vulnerability in Alcoholics Anonymous, as well as find understanding and moral support (see below). But if he is in need of professional help and advice in addition to awareness and understanding, an alcoholism clinic is probably his one best resource.

The many roles played by outpatient clinics are described in the next chapter. In brief, their primary concerns are medical and psychiatric services, and individual and group counseling. These are geared to meet the needs of alcoholics at large as well as hospital dischargees.

The medical and psychiatric services can range from consultation and referrals to critical treatment-on-the-spot, depending upon facilities.

Individual counseling is available to help the patient work out solutions to his very personal problems. This service is not intended to act as an employment or public welfare resource. But the counselor should be able to refer the patient to appropriate agencies in the community to meet these and other special needs.

Group counseling -- or "group therapy," to use the term in its broad non-professional sense -- is the outpatient clinic's major contribution to continued treatment once a patient has emerged from the mental and physical distress of intoxication and withdrawal.

Continued sobriety can only be achieved by changing the alcoholic's attitude and teaching him new ways of dealing with the frustrations that drove him to drink.

In this type of treatment, the patient is assigned to a small, ongoing group of fellow alcoholics who discuss their common "hang-ups" -- i.e., frustrations and temptations which led to their past drinking -- and what they are doing to meet them without resorting to alcohol. A trained leader -- usually a psychiatrist, psychiatric nurse, social worker or counselor -- merely keeps the discussion within bounds. At first, the new patient is inclined to confine his participation and mental note-taking to alcohol, its use and misuse. As he becomes better acquainted with the other members of the group, he finds himself more and more involved in the discussion of more stressful areas of personal and social functioning. Accordingly, the way is cleared for greater insight into his own personality and behavior and those elements which have contributed to his alcoholism. He is then better able to adapt himself to a more meaningful way of living without recourse to alcohol.

Many psychiatrists feel that group therapy is far more effective than individual psychotherapy. Because of the alcoholic's habit of "sneaking" drinks, protecting his supply, and feelings of guilt, he becomes more and more of a "loner" as his illness progresses. In group treatment he once again becomes physically and psychologically involved with other people. Thus, he is pried loose from the isolation he has built up for himself -- not by choice, but because his disease demanded it.

(Both individual and group counseling are more fully discussed in Chapter III.)

DETERRENT THERAPY

Disulfiram (Antabuse) is a drug often prescribed to deter the alcoholic from drinking. It is no "cure." It does not erase the desire to drink. But it does make the consequences of drinking the slightest amount of alcohol so agonizing that even the most confirmed dipsomaniac will abstain so long as it remains in his system.

Normally the liver oxidizes alcohol into acetaldehyde which, in turn, breaks down into acetic acid and next into carbon dioxide and water. Acetaldehyde is a poison. Necessary for its breakdown is a enzyme (acetaldehyde dehydrogenase) which the disulfiram blocks. When this happens, the acetaldehyde rapidly accumulates and within a few minutes, the patient becomes violently ill. He becomes extremely hot and flushed. His blood pressure rises rapidly and a splitting headache develops. Concurrently, he develops a pain in the chest which spreads into the left arm, his heart pounds rapidly, and he finds it difficult to breathe. Suddenly, his blood pressure falls and he may become sick to the stomach and even collapse. He then falls into a deep sleep.

The attack may last up to four hours; but the patient shudders at the thought of experiencing it again.

However, Antabuse has no effect upon the body unless alcohol is taken. It needs a detonator to start the chain reaction. And the only detonator is a drink.

Thus, it acts as a silent policeman to protect the patient's abstinence. The average practicing alcoholic cannot envision life without his favorite beverage to sustain him. Once he starts on an Antabuse regimen, he discovers that sobriety is not only attainable and endurable, but that it can be more agreeable than the way things were with alcohol.

By itself, Antabuse is no panacea to bring about and maintain sobriety. But taken regularly, it acts as a shield against impulsive "slips" which can be serious setbacks in continuing treatment. Once the patient takes his daily dose. he has no decisions to make about drinking or not drinking for the next 72 hours. And it keeps him sober to profit from whatever form of follow-up therapy he may be undergoing.

On the other hand, if a patient who claims that he is "on Antabuse" drinks with no ill effects, the therapist knows that he is not taking his medication as prescribed. It can be reasonably assumed that he has not yet achieved the motivation necessary for any program of recovery.

Because of the reactions that occur when alcohol is taken on top of Antabuse, the patient must have a physical examination before the drug can be prescribed. (Contraindications include uncontrolled hypertension (high blood pressure), coronary heart disease, late stages of cirrhosis, severe pancreatitis, psychoses or brain damage, and sometimes pregnancy.) The patient is given a card to carry with him so he will not be given medication containing alcohol in the event of an emergency. Antabuse should not be administered until 48 hours have elapsed since the patient's last drink; nor should he drink again until at least 72 hours after taking his last pill.

MISCELLANEOUS THERAPIES

There are many other types of therapy, most of which the alcoholism counselor will probably never hear about. But there are several of which he should be aware:

Lysergic acid (LSD) therapy: Research continues on this still unproved method of treatment. Thus far the effectiveness apparently rests in the degree of rapport established between the patient and the individual therapist who attends him on his "trips."

Hypnosis: Used in certain types of psychiatric and psychosomatic illnesses, some practitioners believe hypnosis can be employed in the treatment of alcoholism. Up to now the results have not been very successful.

Conditioned response therapy: The most common of many procedures is to add an emetic to a patient's favorite brand of alcoholic beverage. After several nauseating experiences, he is automatically supposed to develop a distast for the stuff. Chief drawbacks are: (1) that frequent "reconditioning" is necessary; and (2) that patients can often switch to other brands and continue drinking without ill effects.

Psychodrama: This is a form of group therapy wherein the patients act out psychic conflicts. Because of the highly emotional nature of these conflicts, psychodrama should only be employed under the close supervision of a psychiatrist or specially trained psychodrama therapist.

ALCOHOLICS ANONYMOUS

Alcoholics Anonymous is a fellowship of problem drinkers who have banded together in an effort to help themselves and other problem drinkers attain sobriety.

Their program is best summed up in "Twelve Steps" which the members are urged to follow:

1. We admitted we were powerless over alcohol -- that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

While "God" is frequently mentioned in these steps, A.A. members are quick to point out that they "adhere to no particular creed or religion" and welcome agnostics into the fellowship. But the spiritual element does play an important role in the "therapy."

Undoubtedly, A.A. has been responsible for many recoveries in the United States and in other countries. This is not surprising in view of its half million members -- including those not affiliated with any one group -- and the profusion of those groups, which are to be found in practically any sizable community in the country. With "no dues or fees in A.A.," with no rosters kept (to insure anonymity), with no record of those who may attend one or two meetings and then disappear from sight, it is impossible to estimate the percentage of recoveries. But by the sheer weight of the number of alcoholics exposed, any head-count would be high.

A.A. meetings are either "open" or "closed." Anyone interested in the program, alcoholic or non-alcoholic, can attend the former. Closed meetings are for alcoholics only. They are usually sessions in which the participants discuss more intimate alcoholic experiences. Both meetings are presided over by members chosen on a rotating, week-to-week basis -- i.e., no special training is involved.

One consideration in a sick alcoholic's limiting his treatment to A.A. is the fact that there is no medical or psychiatric screening. A "Twelfth Step worker" enthused over his own improvement, may be apt to disregard an underlying mental or physical disorder that is contributing to the woes of the person who has called for help. But on the whole, A.A.'ers are becoming increasingly aware of the physiological and psychiatric complications of the disease. More realize that "first things come first" and that physical and mental blocks must be overcome before the ailing alcoholic is ready to comprehend the spiritual.

Many clinic patients regularly attend A.A. meetings, just as many A.A. members find additional support in clinical therapy and Antabuse.

All reliable resources must be used in treating the alcoholic. So the alcoholism counselor should keep schedules of area A.A. meetings on hand at all times. Alcoholics Anonymous has proved its worth.

SUPPLEMENTAL READING

Alcohol and Alcoholism

A.A. World Service, "Alcoholics Anonymous"

American Medical Assn. Committee on Alcoholism, "Manual on Alcoholism"

Anonymous, "Drinking Game and How to Beat It," Simon & Schuster (for layman)

Block, Marvin A., "Alcoholism, Its Facets and Phases," John Day Company

Fox, Ruth and Lyon, Peter, "Alcoholism: Its Scope, Cause and Treatment," Random House

Jackson, Shirley, "Lost Weekend," Popular Library (fiction)

Jellinek, E.M., "Disease Concept of Alcoholism," Hillhouse Press

Malzberg, Benjamin, "Alcoholic Psychoses," Rutgers University

Mann, Marty, "New Primer on Alcoholism," Holt, Rinehart & Winston

Pittman, David J., "Alcoholism," Harper & Row

Pittman, David J. and Gordon, C.W., "Revolving Door," Rutgers University

Plaut, Thomas F. A., "Alcohol Problems: A Report to the Nation," Oxford University Press

Robert, John, "A Couple of Drinks," Rolf Norman, Riderwood, Maryland (for laymen)

Roueche, Berton, "Neutral Spirit," Little, Brown & Company

Tahka, Veikko, "Alcoholic Personality," Rutgers University

Wallerstein, Robert S., "Hospital Treatment of Alcoholism: A Comparative Study," Basic Books

National Council on Alcoholism pamphlets and reprints:

Anderson, R.H. and Weisman, Maxwell, "Alcoholic in the Emergency Room"

Blakeslee, A.L., "Alcoholism: A Sickness that Can Be Beaten"

Fox, Ruth, "Antabuse as an Adjunct to Psychotherapy in Alcoholism"

Fox, Ruth, "Treatment of Chronic Alcoholism"

Gitlow, Stanley E., "Pharmacological Approach to Alcoholism"

Milt, Harry, "Alcoholics and Alcoholism"

Tiebout, H.M., "Role of Psychiatry in the Field of Alcoholism"

Vogel, Sidney, "Interpretation of Medical and Psychiatric Approaches in the Treatment of Alcoholism"

CHAPTER II

HOSPITALS AND OUTPATIENT CLINICS

On October 6, 1969, the "Journal of the American Medical Association" published "Guidelines for Admission of Alcohol-Dependent Patients to General Hospitals," drawn up by the Committee on Alcoholism and Drug Dependence of the AMA. It began as follows:

"In June, 1966, the House of Delegates of the AMA reaffirmed a statement it had adopted ten years earlier on admitting alcohol-dependent patients to general hospitals.

"That statement referred to the growing acceptance of the fact that such patients are ill and are a medical responsibility. This acceptance, coupled with improved treatment methods and increased knowledge of an experience with alcohol problems, have largely obviated previously cited objections to hospital admission.

"The statment further emphasized the need for each patient to be evaluated individually, and for the possibility of admission to a hospital to be decided solely on the basis of the particular clinical indications observed in the patient at the time and as determined from his history. Exactly the same criteria are applicable to the alcohol-dependent person as to any ill person where hospitalization is being considered as requisite to medical management."

The medical guidelines for addmission followed.

YESTERDAY'S PREJUDICES

Apparently, the original statement by the House of Delegates in 1956 was largely ignored, as well as a similar statement adopted by the American Hospital Association about the same time. A reluctance on the part of general hospitals to accept alcoholics as patients persisted throughout the decade. In some areas, it still persists today.

Past reluctance might be justified. For years, generations, centuries, alcoholism had not been recognized as an illness. The alcoholic was considered a weak-willed sinner whose condition was self-induced and who could stop drinking the moment he resolved to stop. Therefore, it was felt that it was the responsibility of clergymen and the courts to deal with the alcoholic.

Any attitude so imbedded in generations cannot be shaken overnight. And an attitude which equated alcoholism with sin and dereliction could not help but stigmatize it in the public mind.

This stigma did much to firm up many hospitals' reluctance to accept alcoholics as such. Some private hospitals even went so far as to write the taboo into their bylaws. A common practice for physicians who were aware of the severity and the possible ill-effect of their patients' excessive drinking was to have them admitted to such hospitals under a different diagnosis -- e.g., acute gastritis, cardiovascular observation, etc.

Also with the nonrecognition of alcoholism as a disease, medical schools had ignored it in their curricula. The omission had extended to nurses' training schools and to the on-the-job training. This invariably led to poor understanding of alcoholism and unfamiliarity with treatment methods.

As a result of the two -- stigma and unfamiliarity with treatment methods -- hospitals found "ample grounds" in defense of their policies. They could subscribe to the puritanical image of the alcoholic: aggressive, belligerent, a disruptive influence. They alleged that he was uncooperative and demoralizing to other patients. They even claimed that he was a poor financial risk.

A CHANGING ATTITUDE

Today among hospitals, there is an increasing acceptance of the alcoholic as a "legitimately" sick individual in urgent need of medical treatment which at times includes hospitalization.

This is not to be construed that there is now a general open door policy for alcoholics. Far too many hospitals continue to reject these patients. Others, though still reluctant, cautiously admit one here and there. But an encouraging number of major-league hospitals are making more beds available and even setting up additional facilities, such as "quarter-way houses," to meet the needs of the alcoholic patients and thus discharge their obligations to the community.

No small part in changing the attitude has been played by the alcoholic patients themselves. When properly treated, their conduct and behavior can be exemplary and thus they have demonstrated that they are no more disruptive, aggressive, belligerent or difficult to treat than average, non-alcoholic patients.

This "proper treatment" calls for an understanding that alcoholism is an illness. It calls for a degress of empathy with the mental and physical distress the alcoholic patient has suffered and is still suffering. It calls for the same tact, consideration and common sense that is required in treating all patients, no matter what their ailments may be.

Some alcoholic patients may be resentful and antagonistic if they feel that they are being coerced into treatment or discriminated against. But under similar circumstances, non-alcoholic patients are equally resentful and antagonistic.

When he does recover enough to be up and about, the alcoholic patient is usually so grateful for the help he has received, that he will do his utmost to assist other patients and the staff during the rest of his stay.

Nor is his stay an extended one. Once detoxified and sufficiently restored to normal health -- usually six to eight days -- it is far better that he continue his treatment on the outside, once again active in living the life most satisfying to him as a sober member of his community

So it is that alcoholic patients themselves are gradually overcoming the blocks that for years stood between them and acceptance as inpatients.

One of the more positive operations for improving the attitude among general hospitals is supported by the Baltimore City Alcoholism Center. The Center offers consultative services in the treatment of alcoholic patients to the staffs of collaborating hospitals and participates in ongoing training programs for resident physicians and nurses.

In this way, the seeds of new alcoholism programs are sown.

As the seeds germinate, many of the hospitals are willing to open their facilities to students in the Training Program for Alcoholism Counselors, a Federal project operated by the Center. Not only are the trainees afforded practical experience in hospital procedures; they also nurture the new hospital programs through their specialized knowledge of the disease and treatment methods. They engender interest, they supply missing answers in their specialized field of study.

Through this demonstration of activities and usefulness of the trainees during field placement, there is created a demand for permanent alcoholism counselors on the hospital staffs. And thus another step towards better understanding has been achieved.

From a purely ethical standpoint, neither the alcoholic nor any other patients should have to justify their eligibility for hospital treatment so long as they need the institution's help. Even in areas where alcoholism still carries a dishonorable stigma, the alcoholic is definitely a sick person. And as a sick person, he is entitled to the help a hospital should give. Not many years ago tuberculosis, cancer, mental illness and other ailments also carried stigmas. But with public education, the stigmas have been largely removed.

It is most important that admitting personnel be aware of this. The alcoholic patient often comes to the hospital hopelessly resigned to meeting the same kind of rejection he has experienced everywhere else. When accepted like any other patient -- with no recriminations or disfavor -- his feelings of resentment tend to diminish. He is given a psychological head start on the road to recovery.

Many medical schools are giving more recognition and adding new courses in alcoholism to their curricula. The same holds true in nurses' training courses. So as their new graduates join hospital staffs, the old prejudices should lessen and the treatment of alcoholics move ahead still more.

THE GENERAL HOSPITAL COUNSELOR

There are several things a counselor assigned to a general hospital should keep in mind. For the most part there are matters of everyday diplomacy and common sense.

The most important is to adhere to the hospital's policies and precedures whether he approves of them or not. It may be that shadows of old prejudices against alcoholism still becloud certain areas of the institution's operations. They will not be dispelled by his dissenting words or actions, no matter how "enlightening" those words or actions may be. Change of attitude is always a slow process. And change in a veteran staffer's attitude towards alcoholism can best be effected by a counselor's power of example -- but within the bounds prescribed by current hospital policy.

Nor should the counselor tell the doctor how to treat his patients. This is not as banal as it sounds. As mentioned before, medical schools for many years bypassed or took only superficial notice of alcoholism in their curricula. Hence, graduates received little or no training in the diagnosis or treatment of the disease. And hence, a trained alcoholism counselor may be sorely tempted to interject his own diagnosis or recommendations for treatment before he is asked.

On the other hand, the counselor will encounter doctors who recognize their handicap when it comes to alcoholic patients, especially now that the disease has become a matter of public concern and information. These doctors may very well appreciate the unique knowledge the counselor has in this particular field and ask for his opinion. This is particularly true in cases where patients have been admitted to hospitals under other diagnoses, but where drinking could be a major, contributing factor.

In such instances, the counselor is expected to lend advice. But he should wait until the physicians or nurses solicit it, except in cases of emergency (e.g., impending D.T.'s).

The counselor should also be cautioned against interviewing a patient unless so requested by his physician.

The same general rule applies to the counselor's going "on the ward" without the knowledge of the head nurse or nurse in charge at the time. It behooves him to keep on good terms by recognizing their authority.

Finally, one of the counselor's major functions is to impress upon the recovering patient the need for follow-up treatment after he leaves the hospital. As explained in Chapter I, "Inpatient Treatment," the physician can only start his alcoholic patient's recovery program during the short period he is hospitalized. Agitation can be reduced, vitamins, proteins, and minerals can be supplied.

This is the time to let the patient know that his hospitalization is only a start. This is the time, during his first few days of new-found sobriety, when he is most open to constructive advise. This is the time to discuss future plans -- available clinical facilities, Antabuse, Alcoholics Anonymous, clerical counseling, or whatever agencies can serve him best.

This is one of the hospital counselor's most important roles.

RESOURCES

GENERAL HOSPITAL	ADDRESS	PHONE

STATE MENTAL HOSPITALS

Facilities for alcoholics vary greatly in the mental hospitals administered and operated by the fifty states.

Unlike general hospitals -- where a licensed physician or the hospital's emergency room must arrange for inpatient care -- a patient may volunteer for admission simply by signing the necessary forms, or be committed by physicians' certification or an order of the court. (See Chapter VII, "Alcoholism and the Law")

In most state hospitals, the alcoholic patient is still placed with the other mental patients. In states where public intoxication is still a crime, he may find himself in a locked ward.

But in more progressive states, separate alcoholism rehabilitation units (ARU's) have been established apart from the other wards, where all treatment is focused upon getting the excessive drinker back on his feet and returned to a constructive role in his community.

These ARU's follow the basic treatment patterns outlined in Chapter I. There is a "sick bay" to repair the physical damage that has been done, to reduce the agitation of withdrawal, and to take care of other alcoholic after-effects as they may occur.

Once released from sick bay, the patient is introduced to a follow-up program of rehabilitation. This usually consists of individual and group counseling, lectures, moving pictures, Alcoholics Anonymous meetings, occupational or industrial therapy, and possibly the initiation of Antabuse therapy. There is often close liaison with the State Department of Vocational Rehabilitation to help the patient secure employment after he leaves the hospital.

A "structured program" may last anywhere from one to several months.

Except for duties which are the sole responsibility of medical members of the staff, the alcoholism counselor assigned to a state hospital can expect to participate in all these activities. And the general guidelines cited with regard to general hospitals apply here as well.

RESOURCES

STATE HOSPITAL	ADDRESS	PHONE

OUTPATIENT CLINICS

While state and general hospitals are available for those patients whose condition is serious enough to warrant inpatient treatment, the vast majority of alcoholics continue to walk the streets, or at least make a pretense of living everyday lives. They may realize that their families or homes are disintegrating, their jobs jeopardized, or are secretly suffering any of the other well known consequences of excessive, uncontrollable drinking. They are not physically or mentally sick enough for hospitalization. But they, nevertheless, need help.

For them the outpatient alcoholism clinic may be the answer.

These clinics are operated by city and county health departments, medical and mental health centers, hospitals, and other social service organizations. The new patient may come on his own or by referral from a member of his family, his physician, his employer, clergyman, Alcoholics Anonymous, the local office of the National Council on Alcoholism, or any other public or private agency concerned with his health and welfare.

Here is how a typical clinic operates.

CLINICS: INTAKE

If it is quite apparent that the applicant for help needs hospitalization, he is immediately referred to an emergency room, general hospital or state hospital as circumstances indicate. If later, upon discharge, he returns to the clinic for follow-up treatment, copies of his hospital records are incorporated into his clinic records.

Otherwise, the new patient is interviewed by a counselor or other members of the clinic's staff. During this the interviewer tries to gather significant information regarding his personal and family history, his past and present social and economic status, and his usual ways of dealing with stress. Usually family and other social relationships are severely strained or damaged, and there may be real needs in other vital areas of his life (e.g., financial, housing, employment, etc.). The counselor may refer him to other agencies who can help him in these areas. And, of course, his drinking patterns are discussed.

A physical examination is always required. This is to detect any organic disorders which may have resulted from prolonged and excessive drinking. These can seriously interfere with the patient's rehabilitation.

Shortly after the first interviews, the preliminary findings in the patient's case are discussed in a regular meeting of the clinic's staff. If a family physician or other agency has been involved in referring the patient to the clinic, they are invited to participate. They often provide additional information that can have a direct bearing on determining the type of program deemed best for his recovery.

CLINIC: TREATMENT

Essential to a clinic's success in treating alcoholics is a firm belief that, barring severe organic brain damage, every alcoholic can be rehabilitated. The staff members must accept him as a worthwhile human being, deserving of respect, but one who requires specialized treatment without special privileges. The patient must learn to face up to reality and become accountable for his own fortunes and misfortunes, the same as any other citizen in his community.

Unless he has already been exposed to hospital or clinical treatment of his illness, or has spent considerable time in Alcoholics Anonymous, the chances are that the patient has little understanding of the disease. If such is the case, he may be assigned to an orientation group where the medical and psychological aspects of alcoholism are explained. Hopefully, he will be able to recognize himself as an alcoholic -- a most important requisite of successful treatment.

After he becomes aware of the part alcohol has had in disrupting his life, he is assigned to an ongoing therapy group wherein he is most likely to establish

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rapport with the other group members. The group generally meets weekly. It furnishes the support that every alcoholic needs along the road to recovery. The patient becomes friendly with others who have traveled the same road as himself. He rids himself of many feelings of guilt and remorse which he had thought were his alone. He gains insight into the reasons for his past drinking and, through the experiences of others, learns of new ways to meet old frustrations and control his future behavior. The more integrated the patient becomes into the group, the greater support it affords.

When severe personal problems contribute to the patient's illness or interfere in the rehabilitation-process, he receives individual counseling. If it is medical or psychological help he needs, an appointment with the staff internist or psychiatrist is arranged. Other problems may call for the help from social agencies outside the clinic. The counselor can arrange his meeting with.them. Or, as if often the case, the patient may want to talk about problems too intimate to bring up in his group. The counselor tries to help him help himself. All this is a part of the treatment program.

(Individual and group counseling are examined in greater depth in Chapter III, "Counseling.")

Depending upon the condition of the patient upon admission and his response to therapy thereafter, the clinic may sometimes prescribe or even dispense certain drugs. Psychotropic drugs may be prescribed for patients showing excessive anxiety, restlessness or depression, and in occasional cases of acute intoxication where hospitalization is not indicated. Anticonvulsive drugs may be prescribed for patients with a history of seizures.

The clinic may also recommend that the patient take Antabuse on a regular basis. This, however, is only prescribed after a physical examination to be sure that there are no contraindications. (See Chapter I, "Deterrent Therapy.")

CLINICS: PUBLIC EDUCATION

On the premise that "action speak louder than words," the outpatient clinic can often be a stimulus to community awareness of alcoholism as a major health problem. Its everyday operations can do much to mold public opinion in this regard.

The invitation to family physicians and other referring agencies to attend staff meetings where patients' treatment programs come up for review is a case in point. This can cultivate a better understaning of alcoholism among professional persons. It can help to increase cooperation among them and social agencies in assisting the alcoholic.

As an important community service, news media must recognize the clinic and thereby bring it and the problems of alcoholism to public attention.

Civic organizations, church and educational groups, classes in nursing and other social agencies will look to the clinic for participants when alcoholism is the topic of the day.

While involvement in such activities may not be one of the alcoholism counselor's "primary duties," it is nevertheless a responsibility he cannot afford to disregard.

RESOURCES

CLINIC	ADDRESS	PHONE

SUPPLEMENTAL READING

Hospitals and Outpatient Clinics

National Council on Alcoholism pamphlets and reprints:

Bates, R.C., "Treatment of Alcoholism in a General Hospital"

Block, Marvin A., "Hospital's Place in a Program of Alcoholism"

Fox, Ruth, "Alcoholics in a General Hospital"

Fox, Ruth, "Nurse and the Alcoholic"

Morrison, James M., "Chronic Alcoholic in a General Hospital"

Smithers Foundation, "Guidelines for Admission of Alcoholics to Hospitals"

Toner, Mary T.. "Role of the Nurse in the Treatment of Alcoholism"

CHAPTER III

COUNSELING

The alcoholic who is not ready to undergo treatment will often protest, "Only an alcoholic can help an alcoholic!"

That is not true.

But the counselor -- alcoholic or non-alcoholic -- who would help the man or woman whose life is disintegrating because of drinking should thoroughly understand the physical and emotional pain involved before attempting to establish rapport.

The essential quality is one of empathy, which the dictionary defines as "the capacity for participating in another's feelings or ideas." It differs from sympathy in that the counselor does not become emtionally involved, allowing the patient's joys and sorrows to affect his own ability to evaluate and advise.

The effective counselor must not only be able to understand others. He must have a real desire to understand others, to explore the whys of human behavior. And he must have an unconditional, positive regard for the individual patient -- a blend of warmth, acceptance, regard, interest, and respect.

He must continually work on his own self-awareness. He should recognize his own hang-ups and learn to deal with them. One who is able to do this is better able to be a partner in a helping relationship.

He must always remember that he is a counselor, not an analyst nor a judge. Overconcern with personality theories and counseling techniques will endanger rapport, just as premature attempts to arrive at solutions will surely lead to the patient's being short-changed.

Equipped with a knowledge of the physiological and psychological nature of alcoholism and especially of its progressive symptoms (see Chapter I "Alcohol and Alcoholism"), the trained counselor usually is in a position to assess the general status of the new patient who sits before him. He has a broad idea of the physical pains, emotional distress and changing attitudes the alcoholic has already suffered. This may be a small start. But is is an important head start in winning acceptance and evolving a program for recovery.

From that point on it is the counselor's job to translate his general observations into full and meaningful particulars about the highly individual person who seeks his help. Once that is accomplished, they can work together towards reasonable decisions and practical steps to be taken.

Effective relationships between alcoholism counselors and their patients can be broken down into three stages:

The first might be called the subjective period. During this, usually the initial interview, the counselor wins the patient's confidence and establishes his empathy with him. He then gathers as much pertinent information as possible -- e.g., personal data, marriage and family status, employment, hospitalizations and arrests, drinking habits, etc.

The second is an objective stage. The counselor points out to the patient his current status in comparison with known patterns and established facts about the disease. He explains what could lie ahead.

The third stage is one of teamwork. The counselor joins with the patient in building a road to recovery and solving the problems still posed by the past.

THE INITIAL INTERVIEW

The initial interview usually is the most important, not only because "first impressions" tend to linger on, but because it may also be the last.

For a variety of reasons, the counselor may never again set eyes upon his patient. One of the most common -- particularly in outpatient clinics -- is that the patient is not sufficiently motivated to undergo continuing treatment. At the moment, the prospect of a lifetime without drinking is too frightening. He should nevertheless leave the counselor's office knowing that the door will always be open to him, tomorrow or ten years hence.

A sense of security is the key to gaining the new patient's confidence so that he will come back.

So the patient must be satisfied that the counselor will respect whatever confidences he may choose to divulge. He must be reasonably confident that the counselor is not going to berate him as he has been berated in the past. He must be assured that he can lower his defenses and receive understanding instead of recrimination.

The counselor cannot expect to be told pertinent confidences unless the patient has confidence in him.

Also in the initial interview, a "contract" should be established:

The patient must be aware that alcoholism is an illness -- not a sin or a sign of weakness of character. Whether or not he is suffering from that illness will be up to him to decide, if he has not already done so.

If the answer is yes, he has two choices: to accept treatment or to continue drinking. If he chooses the latter, probably, eventually, it will result in custodial care or death.

However, if he sincerely wants to recover, he must accept the fact that he is a sick man who can no longer drink. The counselor and his colleagues cannot do this for him. But they can help him help himself.

Such are the essentials of the initial contract. The counselor can make them clear in any way that best befits the situation or the patient's general attitude at the time. But unless the patient subscribes to them, any recovery program is courting failure.

The primary concern in a counselor-patient relationship is "Where do we go from here?" But significant facts about the patient's past and present are necessary for any reliable "estimate of the situation.

In the course of time, counselors develop their individual methods of eliciting this information. So it would be presumptuous here to advance any hard-and-fast rules about interviewing new patients -- as one would instruct a student in the operation of a computer. However, there are certain basic principles to be considered.

The truism that "the quality of the answer depends upon the quality of the question" is universally accepted. The patient must be made to feel that he has the interviewer's undivided attention. He can perceive the presence or lack of empathy not only by the questions asked, but also by the counselor's overall manner. The tone of voice can be more persuasive than the questions themselves. Questions that reflect accusation and suspicion on the part of the counselor arouse resentment and suspicion in the patient and can quickly erase whatever rapport has been established in the beginning.

Even the pacing should be adjusted to the patient. Too slow a pace may suggest a difficulty in understanding on the part of the counselor. Too fast a pace can imply lack of interest.

Some questions must of necessity be pointed and direct -- e.g., date of birth, marital status, employment, etc. Those are to be expected. Other pointed questions -- such as those dealing with the patient's parental and childhood background -- are more readily answered if the purpose in asking them is explained. But in general leading questions are preferable to those that can be answered yes or no. They can lead to greater insight into the patient's personality.

Then there is the question that slams the door. The patient "clams up." More often than not it touches upon a painful memory which triggers the frigid reaction. It is useless to pursue the point at that time. The counselor can come back to it later in the interview or, as often happens, the patient will inadvertently supply the answer while responding to another leading question.

In the same category are evasions and obvious lies. Few alcoholics will admit to having more than "a couple of beers" before their accidents, arrests or other plights. The first meeting is no time to break down their defenses. Usually "the truth will out" -- that the patient had a pint and a half of whiskey between the two beers -- before the interview is over. The counselor should accept both the lie and its disproval without comment. The same holds true for other camouflages thrown up by the patient.

Nor are all answers verbal. The counselor should listen to what the patient does not say, as well as to what he says. The omissions in his explanations and comments are frequently more revealing than the explanations themselves. At the same time, physical clues can also be expressive of the emotional attitude -- e.g., the sweaty palms arising from fear or a sense of guilt, the folded arms of contrariness, the tears of sheer frustration and self-pity.

The most empathic alcoholism counselor in the world could not hope for a perfect batting average among all the applicants who come to him for aid. Perfect rapport cannot be arranged by an admission desk. Sometimes a patient might better be counseled by a worker in the next room or one down the hall. Or he may gravitate to a new group leader, even after weeks of individual counseling by the person who first interviewed him. In such cases, the counselor should have no hesitancy in "letting the patient go."

The counselor must be able to distinguish between the patients he can help and those he cannot. He should recognize his own capabilities and limitations. It may be that a difficult family or financial situation or some other involved personal problem is causing or substantially contributing to the patient's drinking. When it is apparent that the cause, whatever it may be, is beyond the counselor's ability to help, he should refer the patient to an agency which can. (See Chapter IV, "Referrals and Resources.")

MORE BASICS

Most of the above observations also apply to the continuing counselor-patient relationship. Of course, once the ice has been broken in the initial interviews and confidence established, the alcoholic is not apt to revert to lies and evasions with his counselor or physician. If he has normal intelligence, he will have found out that frankness best paves the way for significant planning and decisions.

Nor are there any precise ground rules to guide the counselor in an ongoing relationship. Success lies in adapting himself to the patient's attitude and, through empathy, helping him to plan ways and means of reaching the goals he sincerely wants to reach. In other words, the counselor has to "play it by ear."

But there are several basic "rules of thumb."

In planning ways and means of reaching objectives, final decisions should be made by the patient, not by the counselor.

One must remember that the average alcoholic comes glutted with unasked for advice -- opinionated guidance supplied by family, parents, employer, best friend and well meaning companions. The patient is tired of advice.

So even if the counselor should know the answers, he should forego the role of mastermind. Better he discuss the pros and cons until the patient can view himself and his situation in the cold light of reality and decide for himself what had best be done to remedy matters. This is not to say that the counselor cannot offer alternatives, nor should he allow the patient to decide upon a potentially disastrous course of action. But when the patient himself makes the final decision -- or believes that he made it -- it becomes a strictly personal matter. It is no longer advice from family, parents, employer, or best friend. It is his own decision and, as such, he has greater confidence in the chances for success, especially with the counselor and his resources to lend support.

Besides being surfeited with advice, the average alcoholic comes oppressed with feelings of guilt and inferiority and loss of self-respect. The counselor should search out the constructive forces in his client. He must believe in them and their potentialities. And then he must make the patient realize them and believe in them, too. He can always cite the truism that every man is superior to the next man in some respect -- physically, psychologically or intellectually. Once that asset is recognized, it can become another steppingstone in planning the road to recovery.

One of the beneficial by-products of counseling is catharsis -- "the process by which repressed emotions and memories are brought to consciousness and released." It is an outpouring of emotionally painful thoughts which the patient has been harboring inside himself with perhaps no one available to console or consult, and which he has futilely been attempting to drown in drink. The counselor-patient relationship offers an opportunity for such purgative relief.

Catharsis should be fostered, but not forced. As he listens, the counselor should be alert to responses by the patient which reflect feeling rather than mere recollection, emotions rather than intellect. Strongly felt sentiments can reveal themselves at almost any time -- e.g., while talking about the family's reaction to his drinking, difficulties on the job, strained relation in the community. The bald recital of an occurence may impulsively be punctuated with the patient's emotional reaction to the event. That is the time for the counselor to encourage him to express his feelings instead of just facts. But his questions and comments should be leading rather than probing, persuasive rather than pressing. Otherwise the patient may crawl back into his private world and slam the door behind him.

GROUP COUNSELING

As a general rule alcoholics are more effectively treated in group therapy than in the traditional one-to-one counselor-patient relationship.

This does not mean that the patient's need for individual counseling is completely superseded when he becomes a member of a group. Strictly personal problems may arise. Help from outside resources may be needed. Periods of uncertainty and depression may threaten his new self-command. In such cases, he may need individual counseling for support.

But for ongoing therapy the group affords a climate which the alcoholic has been avoiding for months or even years. Hiding his drinking habits from others or protecting his supply, he has usually become a loner. As participant in a group, he again becomes a member of society -- a society in miniature, perhaps, but nevertheless, a cooperative body with common aims and interests. It evokes intercommunication and, hopefully, interaction with others -- so necessary in again facing up to reality and normal living.

This escape from isolation is only one of many benefits a patient can derive from group therapy. The interpersonal relationships with others faced with the same illness gradually reduces his own sensitivity. He finds understanding, reassurance and support. As time goes on, he gains greater insight into the origins and evolution of his behavior patterns. He is re-educated in ways of adapting himself to reality. And because the environment is real, not artificial, he can test many of those ways within the group itself.

The group leader -- be he alcoholism counselor, social worker or psychiatrist -- must always remember that the group belongs to its members. His primary mission is to be a good listener, with any outward participation kept to a minimum. The members must feel that they are the ones who are choosing the questions for discussion, arriving at the answers, settling any conflicts or confrontations.

However passive his role may appear to be, the leader must see to it that the discussion does not wander too far away from the subject. He should encourage participation by the silent minority, if any. He should act to relieve tensions and mediate debates. And at all times he should be noting the actions and reactions of the individual members, for these are clues to their progress in the recovery program.

While all these duties might seem to conflict with the leader's role as passive observer, he can usually delegate action to others.

Every group is made up of as many different personalities as there are members. They unconsciously tend to assume various roles which they continue to play week after week. The leader can usually count upon them to function as needed. Among them are:

The Initiator -- introduces new ideas or subjects for discussion.
The Information Seeker -- asks for pertinent facts.
The Information Giver -- always ready to supply those pertinent facts if he can.
The Elaborator -- develops others' comments and ideas.
The Orienter -- raises questions about the direction of discussion.
The Coordinator -- tries to pull ideas and suggestions together.
The Tester -- checks whether the group is ready for decision.
The Opinion Giver -- states what he believes to be the consensus of the group.

Such members -- and other members in other roles -- are the group leader's advocates.

Superficially, it might seem easiest to measure the success of any group by the faithful attendance of its members and its attraction of new members.

But the true effectiveness of a group is best reflected in its contribution to its members' recovery. From time to time, the leader should ask himself these questions:

"Has our group created an atmosphere in which constructive progress can be made?"

"Has it achieved real communication among members?"

"Do the members freely give and freely receive help?"

"Are the conditions such that each member can make his own special contribution?"

"Does it allow conflict and confrontation to be resolved into creative problem solving?"

"Has it evolved acceptable ways of making decisions?"

If the leader can answer yes to all of these questions, he and the group are accomplishing their mission. If not, he had best diagnose the shortcomings and repair them.

GROUP THERAPY AND A.A.

One frequently hears Alcoholics Anonymous vaguely referred to as "group psychotherapy."

In reality, there are many basic differences between the two methods of treatment. But a layman's misunderstanding can be forgiven since both have one aim among others -- to help the alcoholic stop drinking.

The counselor should be aware of these differences because the confusion is a common one.

A.A. "therapy" has already been described (Chapter I, "Alcoholics Anonymous") In balancing method -- it is best to disregard A.A.'s open meetings, "where the general public in invited to attend, and limit comparisons to A.A.'s closed meetings," for alcoholics only.

Both A.A. and clinical groups are open to all alcoholics regardless of race, sex, or socioeconomic status. While the latter are diliberately kept heterogeneous, members of A.A. tend to gravitate to groups composed of racial and socioeconomic peers.

Both stress confidentiality. Outside visitors are not allowed. A.A. closed meetings do not permit the non-alcoholic spouses of members to attend. Clinical groups, recognizing alcoholism as a family disease, urge participation by members' families.

So long as alcoholic patients are under clinical treatment, they are required to attend group meetings, which are usually limited in size -- preferably six to nine participants. A.A. members are not required to attend meetings. Nor are there any limitations as to size. Hence, the same group can vary greatly from week to week in both numbers and make-up.

Leadership in clinical groups is vested in a trained psychotherapist or alcoholism counselor who unobtrusively steers discussion, mediates differences and, when called upon, answers pertinent questions concerning alcohol and alcoholism. A.A. groups are presided over by a "chairman," usually selected weekly on a rotating basis. The only requirement is to be an abstaining alcoholic.

The cornerstone of A.A. therapy is belief in a "God as one understands Him" and reliance upon His power to effect "a spiritual awakening" which will support a new, continuing life without alcohol. Catharsis and reparation for past wrongs commited against others are intended to alleviate guilt. Identification with other members who have succeeded in the program is stressed. Abstinence is the goal.

Clinical therapy, on the other hand, centers on psychological aspects. The alcoholic's nonrational and fantastic life theme is brought out and, through intercommunication and interaction with other group members, is eventually accepted by the patient and hopefully altered. The strenthening of relationships with other group members develops a sense of responsibility both for himself and for others. Full sobriety, not merely abstinence, is the goal.

In A.A., "life membership" is encouraged for continuing support. In clinical therapy, the successful member eventually leaves the group and "stands on his own two feet."

There are other differences, but these are the basic ones. The two therapies do not contravene one another. For many patients they complement each other. When such is the case, the alcoholic can profitably embrace both.

SUPPLEMENTAL READING

Counseling

Clinebell, Howard J. Jr., "Understanding and Counseling the Alcoholic," Abingdon

Harris, Thomas A., "I'm O.K., You're O.K.," Harper & Row

Maltz, Maxwell, "Psychocybernetics," Essandess Special

Mullan, Hugh, "Alcoholism: Group Psychotherapy and Rehabilitation," Charles C. Thomas, Springfield, Illinois

Stewart, David, "Thirst for Freedom," Hazelden Press

Tyler, Mary, "Work of the Counselor," Meredith Corp.

National Council on Alcoholism pamphlets and reprints:

McCarthy, Raymond G., "Discussion Guides for Questions about Alcohol" (set of 3)
Tiebout, H.M., "Surrender vs. Compliance in Therapy"
Vogel, Sidney, "Some Aspects of Group Psychotherapy with Alcoholics"

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CHAPTER IV

REFERRALS AND RESOURCES

As the alcoholic patient needs support, so does the alcoholism counselor. He must be aware of what resources are available in the community to help him help others. He should establish friendly relations with those agencies and know why, when and how to enlist their cooperation.

The ailing alcoholic is like a disabled powerboat in a high sea. The immediate job is to get the motor running again. Even when that is accomplished, navigation is still difficult until the waves stop dashing against the boat, driving if off course.

Just so, the alcoholism counselor's immediate concern is to get the alcoholic detoxified, if necessary, and to relieve the tortures of withdrawal. Only then can the patient take stock of his present condition and rationally comprehend the alternatives facing him.

Although he may elect to embark on a course of continuing treatment for his alcoholism, he may still be buffeted by other rough seas he has created during his capricious conduct over a period of weeks, months, or years. He may be homeless, unemployed, without funds, troubled by a neurotic wife or child, threatened by loss of his family, etc. So long as such contingent woes continue to beset him, it will be difficult to hold to the course. The squalls must be reduced or oil poured on the troubled waters.

Accordingly, the alcoholism counselor must often turn to other social agencies for supportive action. He is not -- nor is he expected to be -- a financial advisor, marriage counselor, legal eagle, child welfare consultant, etc., in addition to handling the many regular duties for which he has been trained.

SOME BASIC GUIDELINES

No matter what other resources the counselor may turn to in trying to expedite his patient's recovery, there are certain rules of conduct he should observe:

1. Refer the patient to the agency best equipped to meet his precise needs and do it promptly. Just as postponing treatment of alcoholism makes recovery more difficult, so can delay in straightening out contingent, personal problems add to their complexity.

2. Have as many pertinent facts as possible before making a referral.

3. Do not release any confidential material without the patient's consent, in writing.

4. Alert the cooperating agency about the patient and his need beforehand.

5. Explain to the patient what he may expect from the cooperating agency, and what they may expect from him.

6. Be sure that instructions to the patient are explicit -- names, addresses, times, etc.

7. After the referral has been completed, follow-up with the patient and/or the agency.

The most frequent areas in which the alcoholism counselor will have reason to make referrals are medical, psychiatric, housing, financial, employment, family counseling, and private rehabilitation services.

Hospitals, outpatient clinics and pastoral resources are discussed elsewhere in this Handbook.

Here, then, are some notes and comments on other services the counselor may be called upon to use.

HOUSING: HALF-WAY HOUSES

To a homeless alcoholic, a half-way house can be an oasis on the journey from purgatory back to normalcy. He has recovered from an acute phase of his illness -- either in a hospital or through outside help -- and is ready, but not quite ready, to resume his role as a useful member of society. He needs support, encouragement, a regained sense of self-respect while he gets his bearings again.

A desirable half-way house offers him an environment where he can best readjust himself. It should afford the relaxation and freedom of a home or club, yet have such rules and procedures as to discourage any return to drinking, on or off the premises.

Ideally, a half-way house should be located within easy walking or bussing distance of unskilled and semi-skilled employment centers.

Usually the resident manager is a recovered alcoholic who has been through the mill, capable of assuming responsibility, and well-suited to help his "guests" in times of stress.

While medical and psychiatric treatment is not a half-way house's function, the manager should be familiar with public and private facilities in the community. Informed professionals should be included on the house's advisory board or consultative committee. Regular A.A. meetings, group therapy sessions and/or discussion groups should be emphasized in an ongoing program designed to help the residents maintain their new-found sobriety.

RESOURCES

HALF-WAY HOUSE	ADDRESS	PHONE

HOUSING: QUARTER-WAY HOUSES

Basically the quarter-way house serves the same purpose as the half-way house -- i.e., it offers the homeless alcoholic a haven between hospital treatment and his return to the work-a-day world.

However, a quarter-way house is in reality an extension of the general hospital sponsoring it. Its patients-residents have recovered sufficiently for discharge from emergency room or inpatient care, but still need medical or other supervised treatment before fending for themselves. Nurses and counselors serve on the staff, while the hospital itself is always available to handle any emergency or relapse.

Admissions to a quarter-way house must be arranged through the hospital's emergency room.

RESOURCES

QUARTER-WAY HOUSE	ADDRESS	PHONE

HOUSING: SHELTERS

Shelters are just what the name implies -- board and lodging for the night, or for an indefinite period.

They range from municipal lodging houses at nominal cost, if any, to "missions" where attendance at religious services is expected of the guests, and "rehabilitative agencies" such as the Salvation Army and Volunteers of America. The latter, in many localities, provide employment at minimal hourly rates.

Almost all private shelters refuse to accept intoxicated persons.

RESOURCES

SHELTER	ADDRESS	PHONE

FINANCIAL ASSISTANCE

Financial insecurity can also jeopardize the health and peace of mind needed to rehabilitate the ailing alcoholic. The distress can be relative -- ranging all the way from lack of carfare to get to a clinic, to a millionaire's retrenchment in the face of a stock market dip.

There is nothing the average alcoholism counselor can do to straighten out his patient's monetary woes. But he does have an ally in the local government's department of social services to help the impoverished patient get over the financial hurdles of day-to-day living.

In years past, states could establish their own durational standards for residence. But today, according to a U.S. Supreme Court decision, all inhabitants of a state -- be it for a day or for a lifetime -- are entitled to welfare benefits.

Anyone applying to a department of social services office for assistance must establish need -- need of food, shelter, clothing, and/or household maintenance. His eligibility for such assistance varies among the states, even among counties and communities within a state. His own income, the size of his family, the family's aggregate income, special diet or laundry needs, utilities in the home, etc., all play a part.

Local departments of social services also have emergency funds for temporary grants to sustain clients until continuing grants are authorized.

Eligibility for medical assistance (not to be confused with Medicare, under Social Security) is usually determined by the local Department of Social Services, too, although the state health department may actually pay the doctor, hospital, and pharmacy bills. A patient can be "medically needy" without being on the general public assistance payroll.

For the destitute non-resident, the local office of the Travelers Aid Society is often a cooperative resource for referral. With eighty-three chapters and over 800 cooperating representatives across the nation, they serve a wide variety of persons ranging from temporarily stranded business men and women to jobless transient workers who find themselves in alien communities. In addition to financial assistance, Travelers Aid also helps clients obtain housing, employment, medical care, etc.

RESOURCES

AGENCY	ADDRESS	PHONE

LEGAL ASSISTANCE

As the convalescent alcoholic emerges from the dream world he has been living in for weeks or months, he often awakes to find himself faced with court actions, or threats of court action, requiring legal advice or representation.

Even for the affluent alcoholic these can be aggravating and threaten his regimen for recovery. For the destitute alcoholic they can be disastrous.

A resource for the latter is the local office of the Legal Aid Association. Legal Aid Bureaus provide assistance to poor people who could not otherwise afford the services of an attorney. They offer the same variety of services as those supplied by attorneys in general, private practice -- but with two exceptions.

They will not represent the accused in criminal cases, where it is the obligation of the court to provide an attorney for defense.

They will not participate in "fee generating" cases. Such a case might be one where the client was struck by a negligent automobile driver and sues, with the lawyer's fee to be paid after damages have been awarded.

However, the Legal Aid Bureau does represent the impoverished in the general run of civil suits, such as troubles with landlords, unpaid bills, missed alimony payments, etc.

For the solvent patient who finds himself in legal difficulties and knows of no lawyer to represent him, local bar associations usually have a "lawyer referral service" to suggest attorneys who may be able to serve.

RESOURCES

AGENCY	ADDRESS	PHONE

EMPLOYMENT

Alcoholism is becoming more generally recognized by industry as a treatable disease and employers more amenable to keeping alcoholics on their payrolls so long as they seek and continue treatment. (See Chapter VIII, "Alcoholism in Industry.") But the unemployed alcoholic in search of a job has two strikes against him. One is the lingering prejudice. The other is the reluctance of employers to hire and train men and women whose stability may be questionable, or whose on-the-job performance may abruptly collapse.

An alcoholism counselor is not an employment agent. He is not expected to maintain a list of unbigoted, or even empathic employers in the community. But there are resources to lend a helping hand.

Local offices of state employment services usually maintain up to date "job banks" which are classified according to occupation or skill, and which list current openings. They also offer counseling service for individual assistance in finding work.

Local and regional offices of Vocational Rehabilitation programs provide without charge medical and psychological diagnoses (to determine capacity for employment), evaluations of vocational potentialities and limitations, counseling, training if necessary, and placement services.

In towns and cities where Community Action Agencies have been established, there are Concentrated Employment Programs (CEP) to help economically deprived residents of the target areas served. CEP works closely with State Employment and Vocational Rehabilitation services, as well as with other civic resources.

Furthermore, every sizable city has privately run "labor pools" where men and women are hired on a day-to-day basis to fill in as needed by established businesses and industries. In general, they offer immediate day labor type jobs for men, stenographic and sales work for women. Since they also pay wages on a daily basis, they can be a practical resource for the patient who needs a quick dollar for food and shelter.

RESOURCES

AGENCY	ADDRESS	PHONE

FAMILY TROUBLES

The miseries besetting a family crippled by alcoholic dissension are many, varied, and detrimental to chances for recovery. (See Chapter V, "Family Involvement.")

When a husband and wife are trying to preserve their home in the face of an alcoholic situation, there are usually so many other frustrations infecting each other that the basic drinking problem is also aggravated. In short, the patient often needs marriage or family counseling in addition to counseling for his alcoholism.

Many alcoholism clinics have marriage counselors on their staffs who are trained to deal with this outgrowth of the illness. Otherwise, there are many privately sponsored agencies specializing in family problems, such as the continental network of voluntary agencies associated with the Family Service Association of America -- e.g., the Family and Children's Society. Catholic, Jewish and many Protestant churches support local bureaus serving the same needs.

The alcoholism counselor should be familiar with such resources in his own community and make prompt referrals as patients' needs arise. But such referrals do not relieve the counselor of his responsibility to attend to the drinking problem involved.

RESOURCES

AGENCY	ADDRESS	PHONE

PRIVATE REHABILITATION

Private rehabilitation facilities are mostly patronized by alcoholics sufficiently motivated to seek treatment on their own, but who prefer a seclusion which public institutions, such as state hospitals, cannot offer.

These centers are not for alcoholics still in need of inpatient hospitalization or carefully supervised, round-the-clock medication. Rather, they offer limited follow-up treatment. The patient should be occupationally and financially prepared to spend anywhere from two weeks to a month or more. Many rehabilitation centers insist upon a minimum four weeks' stay.

One of their chief assets is the opportunity for the recovering alcoholic to live, eat, sleep, and readjust his thinking in the company of other men and women with the same problem and aims.

An accredited, well managed rehabilitation facility should recognize the dietary deficiencies most of its "guests" have incurred and plan its meals accordingly. Individual counseling should be available. It should require attendance at group therapy sessions, as well as A.A. meetings. It may or may not offer physical, occupational or other therapies as well.

In referring a patient who may at some time require urgent medical treatment, the counselor should alert the facility about this need beforehand.

RESOURCES

FACILITY	ADDRESS	PHONE

PRIVATE PSYCHIATRIC HOSPITALS

Private psychiatric hospitals offer the same basic services described in the preceding section on "State Mental Hospitals." The added attraction to some patients is greater privacy and, usually, more individual care.

As a rule, referrals can only be made by physicians.

RESOURCES

HOSPITAL	ADDRESS	PHONE

PRIVATE PHYSICIANS

As indicated in Chapter II, "Hospitals and Outpatient Clinics," medical schools are only beginning to include courses on alcoholism in their curricula. Hence, a relatively small percentage of private physicians have had the training that would quality them to treat their patients for this particular illness.

Most reputable doctors who have not been instructed in the diagnosis and treatment of alcoholism readily admit this limitation and refer their patients to other physicans or facilites who can be of help.

When such patients come to the alcoholism counselor as referrals, he should keep their physicians advised of their progress or lack of progress under treatment.

Then there are the doctors who, by need or by choice, have become interested in the disease and include treatment thereof in their general practice. The alcoholism counselor should have several of these informed physicians included in this list of resources. During the course of his career, he will have occasion to refer patients to them for medical treatment and, possibly, hospital admission.

It is a mutually helpful relationship because the physicians are apt to refer patients back to the counselor for long term follow-up treatment once the medical crisis have passed.

RESOURCES

PHYSICIAN	ADDRESS	PHONE

SUPPLEMENTAL READING

Referrals and Resources

(NOTE: The alcoholism counselor should maintain a file of the services and facilities of all pertinent social agencies, both public and private, in his area. Many national organizations have local ground rules.)

National Council on Alcoholism pamphlets and reprints:

Bailey, Margaret B., "Alcoholism and the Social Worker"
Bailey, Margaret B., "Family Agency's Role in Treating the Wife of an Alcoholic"
Cork, R. Margaret, "Social Workers Can Help Alcoholics"
Major, Robert A., "General Practitioner's Role in Treating Alcoholism"
Wettrick, Marian J., "Social Agencies' Responsibility in the Alcoholism Program"

CHAPTER V

FAMILY INVOLVEMENT

The alcoholic's family needs help the same as the alcoholic does.

The tension in living under the same roof with a drinking alcoholic can warp the thinking of the most rational spouse, bring low the high principles of the most strait-laced parent, shatter the composure of the most even-tempered child. Nevertheless, the spouse, the parent, and the child must often lend substantial support in the alcoholic's program of recovery.

There have been few, if any, prescriptions for them to follow as guides. In the past, this was largely due to the popular concept that alcoholism was shameful and should not occur. The mere fear of exposure was enough to pile tension on top of tension within the family.

Today, with the growing acceptance of the disease concept, the alcoholic's need of support from many sources is becoming more widely accepted. Not only are family members better informed about their roles in the recovery program, but many non-alcoholic members of different families are pooling their interests and experiences to better their performance (e.g., Al-Anon and Ala-Teen).

Be that as it may, there are still no prefabricated programs for all families of all alcoholics, and the tensions are still many and varied. The alcoholism counselor has only generalities to draw upon; and then he must adapt those generalities to fit the personality structures of the individuals concerned.

THE FAMILY IN CRISIS

An often cited study of the many balances that have to be struck in the families of alcoholics is one made by Joan K. Jackson, at the University of Washington School of Medicine ("Quarterly Journal of Studies on Alcohol," December, 1954). Her research covered a three-year period, during which she gathered material on the adjustments made by fifty families, as seen through the eyes of the non-alcoholic wives. Most of her findings would still hold good were the roles to be reversed -- i.e., with the wife the alcoholic. At the same time, the overall study underscores the part played by family relationships in both collapse and recovery.

Prior to marriage, all but a few of the husbands in this group drank in a socially acceptable manner. If one did drink excessively, he kept it well hidden from his fiancee, her family, and friends. Or if he admitted alcoholism, the fiancee had little conception of the nature of his illness and was unprepared for the consequences.

Once drinking becomes a known factor, Jackson found that their combined histories fall into seven general stages:

STAGE 1. Attempts to deny the problem: If the wife suggests to her husband that he may be letting his drinking get out of control, he is resentful and rational discussion is difficult. (This, of course, can happen in any family, alcoholic or non-alcoholic.) If she speaks to close friends about it, they usually assure her that her fears are exaggerated. They may give her advice on how they handled similar situations with their own husbands and convince her that she will soon hit upon the right formula for dealing with hers.

STAGE 2. Attempts to eliminate the problems: Invitations become less frequent and when they do visit friends, drinks are limited or not served at all, emphasizing the reason for the social isolation. As these outside connections diminish, the husband and wife are thrown into greater contact with one another. The former's drinking behavior comes into greater focus. The wife begins to make excuses for his absences from work and her efforts to control his drinking become desperate. But she has no prescribed patterns for handling the situation. Her attempts are hit-or-miss with unpredictable results. Nor will she seek help from outside agencies. That to her would be an admission of failure as a wife and mother.

STAGE 3. Disorganization: Both the husband and wife feel trapped in an intolerable situation with no way out. Fear takes over. Fear of violence, fear of possible insanity, fear of personality damage to the children, fear of relatives' interference, of relatives' ignoring them should an emergency arise. The wife may have learned, after police intervention into one of their squabbles, that outside protection is available. But she still shrinks from seeking outside help. She also avoids sexual contact with her husband, feeling that it no longer involves love or affection. He, in turn, accuses her of frigidity, which makes her doubt her adequacy as a woman. This withdrawal extends to other areas of family life. They are alone and helpless as individuals. Their isolation as a family is almost complete. Their problems seem so shameful that help from others is unthinkable -- they fear that they would meet only rebuff and disgust.

STAGE 4. Attempts to reorganize in spite of the problems: This usually begins with a crisis. There may be no money or food, or the husband may have been violent with the children. Or it may even be that the wife can no longer endure life as they have been living it. (If she should leave, the sequence of adjustments moves directly into Stage 5.) If she does not leave she takes over the family reins. The children look to her for decision-making, instead of their unpredictable father. And by now she has been compelled to seek outside help -- ranging from advice from friends in A.A. and Al-Anon to action by courts of law and state hospitals. In so doing, the wife may regain a sense of self-worth and security from which to venture forth to further constructive action. Her feeling of shame is alleviated as she encounters other husbands and wives in the same boat. Meanwhile the husband is becoming increasingly aware of the gradual withdrawal of respect and affection by the other members of his family. He may "go on the wagon" or undergo treatment as times in a desperate effort to regain what he has lost. This raises the hopes of the others that at last "he is doing something about it." But with every relapse their discouragement grows deeper and the rift between them widen.

STAGE 5. Efforts to escape the problems: The wife leaves the husband. This involves many considerations: money, employment, control of the home, possible separation from the children, etc. (See "Separation," below.) There may be a reconciliation after his promises to "reform." But should he revert to drinking again, the ensuing separation entails less emotional stress than the first time. Or the husband, no longer able to tolerate his loss of status, may desert, thus abruptly forcing the sequence into Stage 6, with no time for the wife to weigh all the pros and cons.

STAGE 6. Reorganization of part of the family: This is substantially similar to the reorganization in other divorced families, except that the wife can rarely sever all relationships with the husband. He may make repeated efforts to come back, even using violence or endangering her job when intoxicated. He may urge the children to act as mediators. He may play upon her sympathy that he is "a sick man" and thereby arouse a sense of guilt that she is the deserter.

STAGE 7. Recovery and reorganization of the whole family: Many new problems arise. The wife cannot afford to be idealistic or overly optimistic. For a long period she has been managing the family. As soon as the husband is re-established as the breadwinner and accumulated debts are paid off, he may expect to reassume his original role as recognized head of the family. The children may not readily accept this change. The wife may find it difficult to conceive of him as permanently sober and be reluctant to relinquish control. She realizes that his reinstatement is important to his recovery, but cannot forget the disastrous events in the past when he failed to meet his responsibilities. If his sobriety was attained through Alcoholics Anonymous, he may throw himself so fervently into their activities that she feels neglected. On the other hand, if she participates in A.A. and Al-Anon affairs, too, the situation may be more tolerable and more easily worked out.

These are only highlights of the Jackson study of alcoholic marriages. The alcoholism counselor can readily gather that he may often be called upon to enlist the help of many outside resources to alleviate the distress of such families. Furthermore, the problem has usually grown into a full-fledged crisis (Stage 3 or 4) before the alcoholic spouse is motivated to seek aid.

THE EARLY STAGES

The counselor should be aware of what can be done, or what should have been done, before that point was reached.

Because recognized male alcoholics outnumber the female, "he" is used in this chapter to indicate alcoholic member of the family.

Also, more families with alcoholic husbands try to weather the storm than those with ailing wives. Because of the greater disrepute associated with alcoholic women, the husband may try to hide his wife's sickness for a longer period than she would cover up for him. Economic concerns and the maternal instinct may also prompt the non-alcoholic wife to hang on until the bitter end.

However, most of the problems considered here apply to both husbands and wives, no matter which one is the alcoholic.

In either case, public sentiment towards them can be ambivalent. There can be a general sympathy for the non-alcoholic spouse while, at the same time, others are blaming him or her for driving the alcoholic mate to drink.

Of course, some spouses were well on the way to eventual disaster before their wedding bells rang out. Many fiancees are aware that their husbands-to-be "drink too much," but are certain that their happy marriage will eliminate that, along with other irritating habits they expect to change. Their sense of inadequacy is accordingly greater as their efforts fail.

Once the problem is out in the open, the situation may be aggravated by unsolicited advice from well-meaning relatives and friends. They can be relied upon to take sides, criticize, pass judgement, or give misinformed guidance which further confuses the demoralized wife.

Her most reasonable and logical move is to get her husband to their family physician or, if he refuses, to go to the doctor herself. Perhaps their usual physician is reluctant to become involved with alcoholics or feels less qualified than one of his colleagues who has specialized in the field. He can at least refer her to that colleague, clinic or agency which can set her straight. Once she begins to understand the nature of the illness, she gains greater insight into her husband's frustrating problem. Her attitude becomes less rejective and he, in turn, may become more receptive to her suggestions and eventually agree to the treatment he so sorely needs.

The included listing of "Do's & Don'ts" for families of alcoholics can be most helpful to a spouse confronted by the shadow of alcoholism for the first time, with no knowledge of how to cope with it, as well as during treatment. The twenty-four points are self-explanatory. They have been printed and reprinted in many forms and are available at alcoholism information centers, clinics and A.A. groups everywhere.

THE INITIAL INTERVIEWS

Once treatment is sought, the interviewer -- be he alcoholism counselor, clergyman or social worker -- should determine the needs of the family unit, as well as those of the patient, that are contributing to the illness. These could be medical, financial, psychological, legal, etc. Appropriate referrals can then be made.

It is most important that the family member closest to the patient, usually the spouse, be aware that alcoholism is a treatable illness. She may have to be assured that she has not been the cause of her husband's malady. (She may have aggravated it, but that is better left unsaid at the beginning.) Nor can she cure it. Her husband must recognized that he is an alcoholic and sincerely want treatment for himself. This helps to free her from feelings of guilt and allows her to concentrate on constructive efforts and support.

While the wife should be interviewed early in the treatment program, whether or not to have her present at the first meeting is a debatable choice.

This is especially true when the wife has projected all their troubles onto her husband's inability to stop drinking. In all probability she has attributed it to lack of will power, moral weakness or sheer perversity on his part. She expects the counselor to read him the riot act, while she takes notes to continue the lecture at home. If the patient attempts to dispute his wife's charges, the counselor will become either an umpire or an impartial observer at a battle which may have been going on for years. It will be difficult for his to establish a trustful relationship with either one of them. And it is highly important that this be done with the patient. The alcoholic must be convinced that the therapist is working for him -- that the interview is only intended to help him, not as a sounding board for his wife's wails of woe.

Then, too, when both spouses arrive together for the intake interview, the counselor has good reason to suspect that the alcoholic husband's chief concern is to placate his wife and pour oil on troubled waters at home. How sincerely is he motivated to seek treatment for his own good? The counselor will have a more difficult time finding out so long as the wife is in the same room.

There are also wives, active partners in a failing marriage, who have been hiding their own shortcomings behind the alcoholism of their husbands. And wives who have starred for so long as suffering martyrs that they are subconsciously incapable of giving up their roles.

Do's

1. Learn the facts about alcoholism -- a variety of authoritative booklets for the layman are available through the National Council on Alcoholism and other organizations. Attend Al-Anon family groups with an "open mind" to learn and benefit from the experiences of others.

2. Develop an understanding attitude to match the facts you nave learned about alcoholism and the alcoholic.

3. Test this attitude by asking yourself: "Are you convinced that alcoholism is really a disease?"; "Is your approach to the alcoholic one of love, indifference or rejection?"

4. Discuss the stituation with a trusted layman, such as a clergyman, social worker or friend, or an individual who has experienced some phase of alcoholism either as an alcoholic or family member.

5. Take it as a matter of course if your alcoholic stops drinking, either as a result of self help or of formal treatment; observe alcohol abstinence completely, because drinking on the part of the non-alcoholic mate is unconsciously resented by the alcoholic and may make him resume drinking.

6. Establish and maintain a healthy atmosphere in the home, with a place in the family circle for the alcoholic member.

7. Encourage new interests and participate whenever possible in recreational or occupational activities enjoyed by your alcoholic; encourage him to see old friends.

8. Be patient and live one day at a time -- alcoholism generally takes a long time to develop, and recovery doesn't happen over-night; accept setbacks and relapses with equanimity. Keep on trying.

9. Approach the alcoholic about drinking only when he is sober, the best time being shortly after about when hangover, depression or remorse are prominent.

10. Discreetly place injurious objects out of sight, and attempt to withhold car keys when your alcoholic becomes intoxicated.

11. Explain the nature of alcoholism as an illness to children in the family; try to spare them from seeing the alcoholic parent in an extremely intoxicated state.

12. Alert local bartenders and police of your alcoholic's condition to help prevent community incidents and embarrassment.

Don'ts

1. Don't preach, nag or lecture. With the alcoholic's characteristic low tolerance of frustration, this will probably cause him to escape more and more into alcoholism.

2. Never use emotional appeals, such as "if you loved me," which only tend to increase feelings of guilt and the compulsive need to drink.

3. Be sure not to make threats you don't intend to carry out or will not be able to follow through.

4. Do not look upon your alcoholic as a moral weakling or completely take over his responsibilities, leaving him with no sense of importance or value.

5. Don't shelter your alcoholic from situations where alcohol is present; don't hide bottles or pour liquor down the sink -- such acts only impel him to establish a secret supply and do not aid him in facing everyday temptations to drink.

6. Never extract promises or place your alcoholic in a position where he or she must be deceitful; pledges are readily given and readily broken, intensifying the alcoholic's guilt feeling and loss of self-respect.

7. Do not argue with the alcoholic when he is drinking or intoxicated -- the response is usually one of negativism and even violence.

8. Never be overconfident or expect an immediate 100% recovery.

9. Don't cover up or make excuses for the alcoholic.

10. Try not to be a martyr. This attitude will only serve to destroy objectivity and usually is sensed by the already remorseful alcoholic.

11. Avoid making an issue over the method of recovery selected by your alcoholic.

12. Never use the children as tools or turn them against the alcoholic in an attempt to cope with your problem.

The counselor may recognize these and many other behavior patterns in non-alcoholic members of the family which are contributing to the patient's trouble. But prematurely confronting them with their own shortcomings entails the risk of frightening them away and losing their future support. Wives of alcoholics seem to be ultra sensitive in this regard.

With all this in mind, many counselors prefer to start by interviewing the patient alone. Shortly thereafter they meet with the spouse alone and then, if prospects are favorable, meet with the two of them together.

Whatever the timing or method used, the counselor should at the outset explain to the spouse that there is no magic formula to stop her husband's drinking or to restore her peace of mind in a day or a week or a month -- perhaps not for several years. She must realize that the medical and psychological damage has been pyramiding for a long time and that it may take a long time for them to repair it -- with the emphasis on "them."

CONTINUED TREATMENT

The primary purpose of having the wife participate in the extended treatment or her alcoholic spouse is to facilitate that treatment. In so doing, she may very well gain insight into herself and better her own behavioral patterns. However, any such benefits should be considered by-products. So far as the alcoholism counselor is concerned, they are important only so far as they relate to the patient, his recovery, and continued sobriety.

The wife's major contribution to the cause can be to ease up the pressure she has been applying. This can be almost instinctive, once she comprehends the nature of the illness and realizes that her husband's irresponsibility has not been "perverse" or "sinful." Hopefully, as she stops referring to him as unworthy and inadequate, he will be better able to face up to his problem and take constructive steps to solve it.

While this new attitude may be brought about in individual or joint meetings with the therapist, group sessions can produce the same or even better results. In these the wife and other members of the family have an opportunity to learn first-hand how other families with whom they can identify have handled the same problem. They learn that relapses need not be disastrous; that longer and longer periods of sobriety between slips are of good omen; how some wives see to the administration of deterrent drugs (e.g., Antabuse); that drinking in front of the patient in the early stages of treatment can be sadistic or nullify progress; how many spouses in the situation have discovered that inability to abstain turned out to be an early symptom of their own alcoholism; reacceptance of the patient into the family establishment, etc.

There is much of the same intercommunication in Al-Anon and Ala-Teen groups. However, the patient himself cannot take part in these discussions, and personal revelations are often softened because of community mores.

If the wife applies at home what she has learned in such meetings, she can do much to expedite recovery of the patient. She may have to be a steadying force until he is able to maintain his own emotional equilibrium. But as he is allowed to reassume responsibilities he abdicated while drinking, he will gradually gain back self-assurance and thus help both her and himself. Sexual relations -- interrupted by toxic impotence or psychological revulsion -- can usually be resumed in due course. All-in-all, she and the other members of the family can be a major part of the therapy, if they so wish.

Of course, there is always the wife who has found satisfaction in being regarded as a martyr. She may find public admiration turning toward her husband upon recovery -- for his "character" or "fortitude" in "licking his problem himself." She may do what she can to regain her throne.

And according to one school of psycho-dynamic theory, there are the wives who were compulsively attracted to weak and dependent husbands. They will make every effort to perpetuate his drinking. This type of situation should be referred to specialized (psychiatric) treatment.

At times, separation may be the only solution.

SEPARATION

While it is common practice to try to preserve a marriage at any cost, in some cases an alcoholism counselor can be doing an estranged couple a disservice by suggesting that they stand fast. That can irreparably damage two or more lives in saving one union for the mere sake of convention.

Separations and divorces in families disrupted by alcoholism apparently follow no religious patterns.

One argument in favor of separation before all vestiges of love and affection have been destroyed is that some day a happier reconciliation may be possible. If they stay together to the point where violence becomes commonplace, the wife will leave in fear she will never forget. If she waits until the atmosphere is one of complete hostility, she will always bear resentments, even if they are eventually reunited.

But separation as a maneuver merely to induce the husband to stop drinking is almost futile. The wife may anticipate that "it will bring him to his senses." She may be right in believing that her leaving him will have an explosive effect. But the alcoholic finds himself in a great variety of explosive situations during the course of his drinking career and yet manages to shrug them off after a brief period of suffering and perhaps remorse. It is immpossible to predetermine exactly which shock or what kind of shock will prompt him to seek sobriety. Separation, when it is used as a weapon, may be the one and again it may not be. By the laws of probability, it has only an outside chance of bringing about the desired effect.

The wife also faces the difficulties alluded to in Stage 5 of Jackson's adjustments of the family of the alcoholic. If there are dependent children involved, these could be multiplied. Will she be separated from them, too, until she can find a job and get reorganized? Where is the money coming from in the meantime? Some relatives say she is making a mountain out of a molehill -- to carry on. Others tell her she will be a weakling if she does not leave.

She must ultimately accept the fact that she is no longer of help to her husband. She reaches a point of emotional exhaustion where his irresponsible behavior becomes an annoyance instead of a nightmare.

Alcoholism ceases to be the chief concern. She may have to seek help for survival. In such cases the alcoholism counselor should refer her to the public or private social agency best equipped to help.

THE CHILDREN

As in any troubled home, the children of alcoholic parents are vulnerable to emotional damage. Many of them bear the scars throughout their lives.

Parents' excessive drinking, per se, does not seem to have the crippling effect that chronic alcoholism does. When questioned by researchers, children have revealed that they most deeply feel the day-after-day quarreling between their parents, closely followed by their rejection by the alcoholic parent.

A child needs to know not only that his parents love him, but also that they love each other. So two basic premises of a child's happiness can be trampled on by an alcoholic parent at once and on the spot. Multiply this by the number of times it occurs in a month or a year, and the hurtful consequences are quite apparent.

In addition to these two basic needs, the child can also become confused and fearful as the alcoholic parent's attitude towards him unpredictably alternates between sober indulgence and drunken brutality. As the situation in the home deteriorates and the non-alcoholic mother assumes more and more of the responsibilities once held by the father, his image of their normal male and female roles may become distorted. And as the child grows older, he or she may prematurely be called upon to take over adult duties. While it is helpful for a youngster to understand the nature of his parent's illness, he should not be saddled with parental cares and responsibilities before he is mature enough or prepared to do so.

In general, preadolescent children are helped by rehabilitating the parents and thereby improving the home. Among older children, it is usually the oldest one of the same sex as the alcoholic parent who is apt to suffer most. They more often require professional treatment.

But so far as the alcoholism counselor is concerned, that is a matter for referral

It often happens that well-intentioned neighbors, social workers, or other observant persons not gross abuse or neglect of children by alcoholic parents. Such cases are usually reported to the law, as they should be, and the court may see fit to take over their custody.

Where the family situation so warrants, the judge may direct the local department of social services to place the children in foster homes until the parents may prove themselves ready and able to reassume the responsibilities of parenthood.

The counselor's job in these cases is to impress upon the parents that a sincere disire and consistent effort to achieve and maintain sobriety will go far in convincing the court that the family should be reunited.

IN CONCLUSION

In dealing with the families of alcoholics, the counselor must keep any planning as flexible as possible.

Many of the problems posed will be outside his domain. He must be prepared to refer them to the appropriate person or agency trained to handle the given situation. And where such a referral is indicated, it should be made as quickly as possible. As in the case with alcoholism, the quicker co rective steps are taken, the better the chance for success.

SUPPLEMENTAL READING

Family Involvement

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Jackson, Joan K., "Adjustment of the Family to the Crisis of Alcoholism"
McGentry, Denis, "Alcoholic in the Family"
McGentry, Denis, "Family Relationships Contributing to Alcoholism"

CHAPTER VI

ALCOHOLISM AND THE CLERGY

One might assume that a major source for alcoholism referrals would be the church.

No others within a community have access to the innermost sanctums of the home to the extent that members of the clergy have. The family doctor enjoys similar entree, but only when physical pain opens the door. The lawyer, too, is invited in -- when legal difficulties arise. And generally the social worker is summoned only in times of distress.

A family's pastor, on the other hand, is welcomed in times of both joy and sorrow. He christens the child, buries the man, and is his confidant in between. He sees the seeds of adversity begin to grow and is there to help root them up when they threaten to choke out well-being.

One would therefore presume that he would be one of the first to recognize the symptoms of alcoholism within a family and one of the first to be consulted.

OLD PREJUDICES

But the roles of the church and the clergy are distorted in many minds by hangovers of bygone prejudices. Particularly in the old concept that the alcoholic was a sinner and a moral degenerate who could redeem himself only if he drew upon his God-given will power to abstain.

This no doubt prompted many members of the clergy to lend their support to the Temperance Movement when it took form in the last century. They stayed with the movement when it ceased to be an advocate of moderation and, instead, took up the hatchet for total abstinence. Later they lent support to the cause of National Prohibition, a noble experiment that failed because it penalized the vast majority of citizens who could drink with impunity to deter the few who could not.

These memories and legends linger on in the minds of some who understandably hesitate to call upon their pastors for help and advice when alcohol is involved in their troubles.

Today, churches are divided over the use of beverage alcohol, with the majority of them taking no stand so long as it is used in socially acceptable moderation. Certain Christian sects forbid its use and regard any drinking as a sin -- a restriction and a discipline they have the privilege to impose upon their adherents. Others condone its use, but condemn it abuse -- e.g., willful drunkenness. However, many of these and still others now recognize alcoholism as a disease and believe that they should play an active part in treating it.

NEW ATTITUDES

The new attitude is reflected in a declaration made by the General Board of the

Protestant National Council of Churches in 1958:

> "The churches share a pastoral concern for alcoholics, problem drinkers and their families. We recognize that once drinking has passed a certain point it becomes alcoholism, an affliction which cannot be met effectively by the unaided efforts of the victims. Alcoholics are persons in need of diagnosis, understanding, guidance and treatment. They are especially in need of pastoral care and the divine love which the church can bring them."

A similar position had previously been taken by the General Assembly of the Presbyterian church:

> "Alcoholics, as well as their families, need the full ministry of the church. We recognize that once drinking has passed a certain point, alcoholism is a disease: that is, the drinking cannot be stopped by a mere resolution on the part of the drinker. He needs treatment, not punishment; understanding, not condemnation."

In 1966, the General Board of Christian Social Concerns of the Methodist Church officially recognized that alcoholism is a disease requiring competent help, and that the church's fellowship should be numbered among the resources available for prevention and rehabilitation. This was a major breakthrough for a church which traditionally adhered to a policy of total abstinence.

The Roman Catholic Church has taken no official stand on the matter. However, their endorsement of "guest houses" for the rehabilitation of priests in Detroit, Michigan and Rochester, Minnesota implies tacit recognition that alcoholism is a treatable disease.

Wine plays a major role in the religio-social web of the Jews. Drinking is acceptable, especially if it is done within the family or the home. Intoxication is condemned. A traditional watchword is, "To be a drunkard is to cease to be a Jew."

Whatever the hierarchy may stipulate, most important to the individual alcoholic seeking treatment are the attitudes of the local pastor and his congregation.

Even these may differ. There are many churches where the minister urges teetotalism upon parishioners who, nevertheless, continue to maintain their membership in the freely drinking world around them. This is known in clerical circles as "preaching from a dry pulpit to wet pews."

So it is understandable how alcoholics and their families, when help is needed, may look to their clergymen with mixed feelings. There are both assets and liabilities involved.

LIMITATIONS OF THE CLERGY

One limitation is that many alcoholics -- and non-alcoholics, too -- see their pastor in judgmental roles. More often than not, the image was first impressed upon them in childhood by reverential parents and the feeling has remained. To them, the minister is a commanding officer appointed by God -- or at least His adjutant general -- whose word is law.

Invariably, the alcoholic carries with him a sense of guilt. It may be neurotic or it may be based on fact. In either case, to him it is real. And the last thing the diffident sufferer wants is to go on trial. So instead of seeking out pastoral help, he will do all he can to evade it.

Of course, there are those whose egos thrive on rigid criteria and stern discipline. For them "judgmental" counseling might mean their salvation.

A second limitation of clerical counseling is the possibility that the alcoholic may look upon his pastor as a father figure. If his own father was hostile and demanding, there may be a psychological transference of those same traits to the pastor. The result will be much the same as it is with the judmental image

On the other hand, if he recalls his father as an ungrudging benefactor, openhanded in times of need and always standing by to help in emergencies, he may try to maneuver his minister into accepting the same role. If he succeeds, both he and the minister will feel pangs of guilt and any chance of a helpful relationship will soon evaporate.

Then there are the many demands made upon a clergyman's time. He is called upon to work individually with many persons in many areas of distress. And the average alcoholic needs counseling on a continuing basis for effective recovery. The clergyman may not have that time to give. In many instances alcoholics have misinterpreted this as rejection on the part of the minister and have accordingly shied from seeking much needed help elsewhere.

Still another limitation is the delusion that "only an alcoholic can help an alcoholic." Once a victim has had this idea implanted in his mind, it is almost futile to point out that medical doctors need not have suffered the ailments they treat -- that "one does not have to be an egg to know what an omelet tastes like."

It might be that the clergyman, unsuspected by most of his congregation, is himself a recovered alcoholic. That does not necessarily mean that he knows what prompted his own return to sobriety. By contrast, a non-addicted clergyman may be able to plumb deeper, more meaningful levels of emotions contributing to the illness. But the alcoholic parishioner, deluded by the above misconception, is not likely to be convinced otherwise.

ASSETS OF THE CLERGY

Probably the greatest asset a pastor has is his intimacy with the victim and the family. If he is aware of the symptoms of alcoholism, he runs a good chance of being the first to detect the onset of the disease. He is thereby in a position to suggest treatment before its relentless progression makes recovery more and more difficult.

If diplomacy will not permit an immediate and direct approach, he can always intimate to the alcoholic or the family that he is aware of the "problem" and is ready to help if and when called upon. Such offers are sometimes accepted months and years later, after the problem has become a crisis.

A second asset is the faith of the alcoholic parishioner and the family. If they are truly devout or "church workers," they are apt to have implicit confidence in their pastor's ability to help solve a wide variety of personal and domestic problems. They will heed what he says. If he suggests that they seek treatment -- through his own counseling or from an outside resource -- they are almost certain to go along with his advice.

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Still another asset is the training of most clergymen in a dynamic ministry. They are taught in their seminaries that personal problems cannot be solved nor conversions effected overnight. Thus, they learn to regard counseling as a continuing process, perhaps a long program of trial-and-error, but always directed towards a productive goal.

With this background they can better accept the fact that sobriety, for an alcoholic, is not only a matter of attainment, but also a long process of maintaining it against the unremitting forces in his way of thinking which can lead to complacency, then failure.

One other asset the clergy has to offer is that no fees are usually charged. Active alcoholism is an expensive illness. A man can exhaust his savings as well as himself.

CONSTRUCTIVE COOPERATION

With these assets and limitations duly considered, the alcoholism counselor will usually find a number of allies among members of the clergy in his community.

He need not look to the person who still considers the drinking of alcohol as a sin. Such a man is probably as addicted to his opinion as the alcoholic is to his bottle.

But their numbers are steadily decreasing. More theological seminaries are familiarizing students with the medical and psychological aspects of alcoholism. More public and private agencies are conducting clinics and seminars for ordained ministers, priests and rabbis. More space in clerical publications is being given to the problem. Whatever help an effective alcoholism counselor can offer them is usually welcomed.

Armed with this knowledge, a church pastor is in an excellent position to utilize the inherited or acquired assets he already has to counsel alcoholics and their families. Presumably, as a member of his profession, he also has understanding and compassion -- that is, objective understanding and compassion with a minimum of emotional involvement.

The clergyman cannot be expected to assume the full burden himself, nor should he do so. It has been said that the eventual goal of ministerial counseling is referral. When it is obvious that the alcoholic is in need of medical help -- either acute or chronic -- the wise pastor will immediately refer him to his family physician, clinic or hospital. With the thin line of distinction between alcoholism and psychosis, psychiatric treatment is often indicated. And with the limitation of time, as mentioned above, the pastor might do well to refer alcoholic and family to a clinic, Alcoholics Anonymous, or some other reliable resource for extended therapy.

Such referrals may call for difficult decisions. In taking prompt action, the minister may fear that he is abdicating his role and running a risk that the alcoholic and the family may feel rejected. On the other hand, if he does not act promptly, he may be reducing the chances for recovery.

This is where rapport between counselors and the clergy can be of greatest value.

By keeping in contact with the alcoholic, the family and the counselor after referral, the pastor can dispel any illusions of rejecting his charge. At the same time, the alcoholism counselor should keep the pastor aware of his patient's progress, just as he would keep a family physician advised.

In this way a high level of constructive cooperation can be attained.

REFERRALS

PASTOR AND CHURCH	ADDRESS	PHONE

SUPPLEMENTAL READING

Alcoholism and the Clergy

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Keller, John E., "Ministering to Alcoholics," Augsburg Publishers
Shelley, Harry E., "Alcoholism and the Churches," Baltimore City Health Department
Shipp, Thomas J., "Helping the Alcoholic and His Family," Prentice-Hall
Woodruff, C. Roy, "Alcoholism and Christian Experiences," Westminster Press

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Verdery, E.A., "Pastoral Counseling and the Alcoholic"

CHAPTER VII

ALCOHOLISM AND THE LAW

"The individual who can control his drinking and does not do so is irresponsible and should be punished," says Dr. Marvin Block, former chairman of the Committee on Alcoholism of the American Medical Association.

The key word is "control."

For countless years it was entirely disregarded. The irresponsible drinker, as defined, and the drinker who was powerless over alcohol were catalogued by the law as two of a kind and dealt out the same punishment when they misbehaved -- "fine or imprisonment, or both."

According to legal philosopher, the effectiveness of any threatened punishment rests in four factors: Its severity; the certainty that it will be imposed; the speed with which it will be imposed; and the ability of the wrongdoer to control his own behavior.

We know today that the alcoholic is a sick person, unable to control his drinking and resultant actions. So the threat of punishment is no deterrent to him. Nor will the punishment itself have any appreciable effect upon him. To him the jailhouse often becomes a home away from home, equipped with a revolving door to facilitate his recurrent stopover.

Nevertheless, public intoxication remains a crime in all but two of our fifty states (Maryland and Hawaii), regardless of the defendant's control or lack of control. Is it a vestige of Salem witchcraft when any mental nonconformity was ascribed to evil spirits and the accused one punished in order to drive them out? Or is it that the behavior of the inebriate -- no matter what his degree of control -- is antisocial and a menace to others? He should accordingly be confined to a penal institution until he learns not to act the way he does?

Disregarding the futility of so punishing chronic alcoholics, they are stigmatized by such processes of law -- i.e., on the premise that criminals are social outcasts, alcoholics are treated as criminals, therefore, alcoholics are outcasts of society, instead of the sick men and women they really are.

CHANGING ATTITUDES

In 1966, two important Federal Court decisions reflected a growing awareness that alcoholism is an illness, not a crime.

The first was that of Driver vs. Hinnant in North Carolina. The 4th U.S. Circuit Court of Appeals held that to convict a chronic alcoholic for public intoxication, an inherent symptom of an illness, would violate the 8th Amendment to the U.S. Constitution forbidding "cruel and unusual punishments." The decision did not nullify the North Carolina statute, which was intended to discourage public drunkenness. The decision merely underlined that no criminal conviction could follow an arraignment where "the accused's helplessness comes to light."

Later in the same year a similar case came up before the District Court of Appeals in Washington -- Easter vs. District Columbia. Again it was ruled that a chronic alcoholic cannot be branded a criminal because of his compulsive drinking. And again it was pointed out that his public intoxication was a symptom of a serious illness.

The hopes of those who were crusading for general legal recognition of alcoholism as a disease, not punishable by law, suffered a slight setback in 1968 in the case of Powell vs. Texas. In a five to four decision the Supreme Court of the United States ruled that chronic alcoholism is no defense against a charge of intoxication in a public place. Influencing this close opinion was a current, nationwide lack of facilities for the care and treatment of alcoholics. Mr. Justice Thurgood Marshall stated: "The picture of the penniless drunk propelled aimlessly and endlessly through the law's revolving door of arrest, incarceration, release and re-arrest is not a pretty one. But before we condemn the present practice across-the-board, perhaps we ought to be able to point to some clear promise of a better world for these unfortunate people. Unfortunately, no such promise has yet been forthcoming."

Meanwhile, in 1967, the President's Commission on Law Enforcement and Administration of Justice included in its report, "The Challenge of Crime in a Free Society," four recommendations concerning alcoholism:

1. Drunkenness should not in itself be a criminal offense. Disorderly and other criminal conduct accompanied by a drunkenness should remain punishable as a separate crime. The implementation of this recommendation requires the development of adequate civil detoxification procedures.

2. Communities should establish detoxification units as part of comprehensive treatment programs.

3. Communities should coordinate and extend aftercare resources, including supportive residential housing.

4. Research by private and governmental agencies into alcoholism, the problems of alcoholics, and methods of treatment, should be expanded.

THE MARYLAND LAW

In nearby Maryland, medical, legal and legislative authorities had been sifting the evidence presented in the above cases, as well as examining conditions in their own backyard. They found that their criminal laws in this regard had been ineffective. They came to the conclusion that alcoholics and chronic public inebriates should be handled through public health, welfare and rehabilitative programs.

Acting on their recommendations, the state legislature passed the Comprehensive Intoxication and Alcoholism Control Act of 1968, the first public law of its kind in the nation.

STATE OF MARYLAND—:—DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DEPARTMENT OF MENTAL HYGIENE

BALTIMORE, MARYLAND

VOLUNTARY TREATMENT AGREEMENT FOR ALCOHOLICS

I desire treatment at ....
(Name of Institution)

under the provisions of Section 11, Article 59 of the Annotated Code of Maryland, with which I am acquainted. In accepting such treatment as the Superintendent may direct, I agree to abide by the rules and regulations of the institution and to give the Superintendent written notice of my intention to leave at least seven days prior to my departure.

Signed ....

....
(Print Name)

....
(Address)

....
(Date)

PHYSICIAN'S INDORSEMENT

I have examined the above person and believe that (s)he is in need of treatment as an alcoholic in an institution for mental disorders, and that (s)he is able to comprehend that act of voluntary admission. I certify that I am duly licensed to practice medicine in the State of Maryland.

Signed ....

....
(Print Name)

....
(Address)

....
(Date)

Any person signing this agreement must be shown the Section of the Law printed on the reverse.

"The services and programs of the Department of Mental Hygiene are provided on a non-discriminatory basis and in compliance with Title VI of the Civil Rights Act of 1964. Any complaints regarding alleged discrimination may be filed in writing with the Commissioner of Mental Hygiene, 301 W. Preston Street, and the Regional Director, Region III, Department of Health, Education and Welfare, Charlottesville, Virginia."

(Over)

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ADMISSION AND DETENTION OF VOLUNTARY PATIENTS

Section 11. Voluntary Admission

(a) Any facility licensed by or under the jurisdiction of the Department may admit for purposes of care or treatment, or both, any person over the age of 18 years who has any mental disorder which is susceptible of care or treatment and who requests admission to such facility. Veterans of the Armed Forces of the United States may be admitted to a Veterans' Administration Hospital without regard to the provisions of this Section.

(b) No person shall be admitted under the provisions of this section unless his condition is such that he is able to understand the nature of his request for admission, is able to request his release and is capable of giving continuous assent to his retention by the facility.

(c) Admission to a facility under the provisions of this section may be obtained by an informal or a formal application. Informal voluntary admission may be accomplished by a simple request for admission. A person admitted informally may leave the facility at any time between 9:00 A.M. and 4:00 P.M. unless, after initial admission, his admission status has been changed in accordance with this subtitle.

(d) Voluntary admission may also be accomplished on the basis of a formal application. Such application shall be in writing, shall contain such personal data and be in such form as the Department may require. No person admitted to a facility on the basis of his formal request for admission may be detained for more than three days, except as provided in subsection (e) below, after having given notice of his desire to leave the facility, unless, after initial admission, his admission status has been changed in accordance with this subtitle.

(e) Patients admitted pursuant to Subsection 11 (d) above, primarily for care or treatment of alcoholism, may be retained by a facility for a period not in excess of seven days after the patient has given notice of his desire to leave the facility, unless, after initial admission, his admission status has been changed in accordance with this subtitle.

(f) No patient admitted pursuant to this section may be retained by a facility for any period in excess of one year, unless his admission status has been changed after initial admission, or, unless at the expiration of each one year period of inpatient residence, the patient executes a new application. In the event the patient was initially admitted on an informal basis and such status has not changed, he shall execute a formal application for admission or the facility may not retain him after the first anniversary of his initial admission.

STATE OF MARYLAND—:—DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DEPARTMENT OF MENTAL HYGIENE

BALTIMORE, MARYLAND

Physicians Certificate for Mentally Disordered Alcoholics

Patient's Name					
	Last	First	Middle	Maiden	Soc. Security No.

Permanent Address______________________________

Street Town State Veteran - No ☐ Yes ☐

Baltimore City Resident ☐ County Resident______________________________

Name of County Number

Birthdate	Age	Race	Religion	Family Physician - Name - Address
Birthplace	Sex	Marital Status	Occupation	

Next of Kin Name	Address	Phone	Relationship to Patient	Certifying Physician - Address

At the time of my examination, the patient showed the following symptoms:

Physical (Illness, Injury, Deformity)______________________________

____

____

Mental (History and Mental Status)______________________________

____

____

____

____

Most recent Psychiatric In-Patient Care No ☐ Yes ☐	Hospital	Location	Date

Is Patient Suicidal? No ☐ Yes ☐	Is Patient Homicidal? No ☐ Yes ☐	Is Patient on Medication? Name of Drug No ☐ Yes ☐

Additional Informant: Name______________________________Address______________________________

I HEREBY CERTIFY THAT ON______________________, 19____, I, a graduate of ______________________ Medical College, am licensed to practice in the STATE OF MARYLAND, personally examined the above named patient and do believe said patient is a mentally disordered alcoholic and that the disorder is of a character which, in my opinion, requires that said patient, for the protection of himself or others, be placed in a hospital in which the mentally ill and alcoholic are detained for care and treatment. I am not related by blood or marriage to said patient, nor do I have any financial interest in the facility in which it is proposed to place the patient. I further certify that this certificate is signed and made within one week of the examination of the patient.

Signed:______________________________Date:______________________________

"The services and programs of the Department of Mental Hygiene are provided on a non-discriminatory basis and in compliance with Title VI of the Civil Rights Act of 1964. Any complaints regarding alleged discrimination may be filed in writing with the Commissioner of Mental Hygiene, 301 W. Preston Street, and the Regional Direction, Region III, Department of Health, Education and Welfare, Charlottesville, Virginia."

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INSTRUCTIONS FOR COMPLETION OF THE PHYSICIANS CERTIFICATE FOR MENTALLY DISORDERED ALCOHOLICS

HOSPITAL ADMISSION PROCEDURES FOR MENTALLY DISORDERED ALCOHOLIC PATIENTS

To admit a mentally disordered alcoholic patient to a State Hospital, it is necessary to comply with A) legal procedure and B) hospital admission policy.

Procedures for admission of mentally disordered alcoholic patients on the recommendation of two physicians:

A. Legal Procedure:

1. Admission on written request of any person having a legitimate interest in the welfare of the patient. (Section 12, Article 59, Annotated Code of the State of Maryland, as amended July 1, 1970.) The mentally disordered alcoholic may be admitted to a mental hospital on the written request of any person having a legitimate interest in the welfare of the patient. The written request and the "Physician's Certificate" of two licensed and qualified physicians as specified in the above section of the Code must be submitted to the hospital at the time of the patient's admission.

B. Hospital Admission Policy:

1. The person who is responsible for the decision to request the admission of the mentally disordered alcoholic patient to a mental hospital shall first call the Pre-Admission Service of the hospital (phone numbers below.) The hospital will arrange an interview with the patient before his formal admission. In cases of emergency, the Pre-Admission Service shall receive such notification so that the patient can be admitted without the Pre-Admission Interview:

Phone numbers for Pre-Admission Services are:

Crownsville.State Hospital, Crownsville, Maryland	MI 7-5200
Eastern Shore State Hospital, Cambridge, Maryland	AC 8-0800
Springfield State Hospital, Sykesville, Maryland	787-2100
Spring Grove State Hospital, Catonsville, Maryland	747-4400

2. The hospital will make no effort to retain an alcoholic admitted on two physicians' certificates and the request of anyone for more than seven days after the patient has notified the superintendent in writing of his intention to leave.

HOSPITAL ADMISSION CENTERS:

(The place of residence determines the hospital to which the alcoholic patient must apply for admission.)

CROWNSVILLE STATE HOSPITAL

All alcoholic patients from the following areas:

- Anne Arundel County
- Calvert County
- Charles County
- St. Mary's County

BALTIMORE CITY POSTAL ZONES

1
2
5
6
13
22
24
25
31

EASTERN SHORE STATE HOSPITAL

All alcoholic patients from the following areas:

- Caroline County
- Dorchester County
- Kent County
- Queen Anne's County
- Somerset County
- Talbot County
- Wicomico County
- Worcester County

SPRINGFIELD STATE HOSPITAL

All alcoholic patients from the following areas:

- Allegany County
- Carroll County
- Frederick County
- Garrett County
- Howard County
- Montgomery County
- Washington County

BALTIMORE CITY POSTAL ZONES

8
9
10
11
12
14
15
16
17
18
34

SPRING GROVE STATE HOSPITAL

All alcoholic patients from the following areas:

- Baltimore County
- Cecil County
- Harford County
- Prince George's County

BALTIMORE CITY POSTAL ZONES

7
23
26
27
29
30

This law does more than strike out public intoxication, per se, as a criminal offense. It establishes a broad health and social program of alcoholism education, treatment and control.

The responsibility for state leadership is vested in the Division of Alcoholism Control of the State Department of Mental Hygiene, which is directed to "consult and collaborate with public and private departments, agencies, institutions and organizations." The Division accordingly acts in a consultative capacity for local health departments, social agencies and other persons or organizations in the alcoholism field.

The law specifies that it is the responsibility of the local communities to establish detoxification units, inpatient treatment, aftercare facilities, halfway houses, services and shelters for those incapable of being rehabilitated, etc.

The immediate effects were an increase in the number of patients admitted to state hospitals and making use of outpatient clinics, a greater demand for alcoholism counselors, and a changing attitude towards alcoholics as sick patients, instead of sinful or perverse untouchables. More general hospitals began accepting patients with diagnoses of alcoholism. And above all, doors were at last opened to public education, training, and coordination of services in a field that had long been a stepchild in medical and social circles.

ADMISSION TO STATE HOSPITALS

Under Maryland law, persons suffering from alcoholism may be admitted to state mental hospitals in four ways:

Voluntarily - The alcoholic seeking treatment may sign a "voluntary treatment agreement." If he so desires, the alcoholic can leave the hospital before he completes the full treatment program by giving a seven-day written notice of intent to leave.

By two physicians' certificates - An alcoholic may be admitted on the written request of any person having a legitimate interest in the welfare of the patient, supported by certificates signed by two licensed physicians. The hospital will make no effort to retain an alcoholic so admitted for more than seven days after he has notified the superintendent in writing of his intention to leave.

Civil commitment - If the medical officer in charge of a detoxification unit believes that a patient is in need of further hospitalization, he can file a petition to this effect with the court. If the judge or magistrate is satisfied that the request is justified, he may commit the alcoholic patient to the hospital for a period not to exceed thirty days from the date of original admission.

Criminal commitment - A judge or a trial magistrate can also commit an alcoholic defendant in a criminal case to a state hospital for treatment and observation "under such terms and conditions as he may determine." Presumably, the judge or magistrate would not impose an unrealistic term of commitment; and the hospital should make certain that the prisoner receives treatment, even if he is confined to a locked ward.

COURT COUNSELOR PROGRAM

The City of Baltimore is the stamping ground for some forty per cent of Maryland's known alcoholics. As would be expected, when public intoxication was a punishable offense, they jammed municipal court calendars, especially on Monday mornings. They were often dealth with in an assembly line manner.

All too often a judge had to determine right then and there the destiny of an arrested alcoholic. He had never been told, not even in law school, how to differentiate between irresponsible drunkenness and alcoholism. He may have heard of Alcoholics Anonymous, but probably had never attended a meeting. His A.A. friends did not identify themselves as such, and only discussed the subject among themselves. He might have been aware of rehabilitation agencies, but knew little about their programs. In short, he needed a trained professional to call upon for advice.

About a year before the state law was enacted, the Baltimore City Alcoholism Center succeeded in having two trained counselors attached to municipal courts to serve in this capacity. Later more counselors were added. So by the time the law went into effect, they were at least conversant with judges and court procedures, and vice versa. Today, the relationship is an established one.

While legally alcoholics have been granted a bill of rights of a sort, their illness is no blanket defense for all infractions of the law. Some are rightfully charged with disorderly conduct -- just as abstainers are. An alcoholic who commits a felony while intoxicated is still held accountable for the crime itself.

Today in Baltimore, an alcoholic may be guilty beyond the shadow of a doubt. Legally he may be subject to imprisonment. But the judge may ask himself, "Is imprisonment going to help or hurt this man? To what extent did his alcoholism play a part in his wrongdoing? Would treatment, rather than punishment, be more apt to avert a recurrence of his crime?"

So he calls in the court alcoholism counselor to consider facilities for treatment. As a result, he may commit the prisoner to a state hospital for alcoholic rehabbilitation. Or he may place him on probation and turn him over to the counselor to arrange for rehabilitation on the outside.

If the counselor takes over, he acts in much the same way as he would outside the courtroom. He may recommend hospitalization. He may refer the alcoholic to an outpatient clinic for medication and other follow-up treatment. He determines any need for food, shelter, employment, etc., and makes appropriate referrals to meet those needs, too.

Admittedly the procedures are not 100% effective. But they have helped to keep hundreds of helpless individuals out of the city's jail.

WIDER IMPLICATIONS

Maryland's findings have been cited here because this state's alcoholism control law was the first to be enacted and is the longest in operation.

As short as that time may be, already certain clear facts have emerged from the settlings of bygone practices that should be thought-provoking to jurists, legislators and their electors everywhere.

With the new frame of reference, it has become increasingly evident that the profitless imprisonment of alcoholics is a waste of manpower, the court's time, and the taxpayers' money. Dr. Marvin Block has also said, "It is estimated that one alcoholic patient rehabilitated into society will pay for ten others who may still require care. This means that if 10% of the public charges suffering from alcoholism in any given state can be rehabilitated, the state will be ahead economically. This is indeed a good investment, and most states should consider it carefully."

Such consideration entails a careful weighing of the relation between alcoholism and existing state laws, as well as the relation between alcoholism and communities within the state. Any disease or addiction allowed to run rampant, untreated and uncontrolled, can become epidemic -- in Happy Valley or on Poverty Row. Laws must be equitable to those who are sound in mind and body as well as to those who are ill. But until recent years, the chief obstacle to the enactment of constructive legislation has been the hesitation to recognize the alcoholic as an ill man.

Theoretically, the solution would seem to be to pass a national law meeting the requirements of all the states. But the temperaments of the fifty states are as diverse as those of fifty men and women picked at random in a shopping center. It would be extremely difficult to draw up a Congressional bill acceptable to all their lawmakers. And enforcement would be even more formidable. The country discovered this in futile attempts to carry out the provisions of the unsuccessful national prohibition act (1920-1933).

However, the Federal Government is making strides in helping thoses states which want to help themselves in meeting and treating the problem of alcoholism within their borders. Slowly but surely more and more funds are being earmarked to help states, counties and communities to implement their own legislation and programs in this field. Successive bills introduced in recent Congressional sessions are becoming more and more liberal. As in most legislative actions, it takes time and the pressure of public opinion to achieve success.

The alcoholism counselor's role in this is to "let his light so shine among men that they may see his good works." As the benefits derived from his efforts -- combined with those of his fellow workers -- are sought out by more alcoholic and non-alcoholic persons involved by the problem, so will public support mount to help attain desirable legislative goals.

HIGHWAY SAFETY

In a report submitted to Congress in 1968, the Secretary of Transportation stated that "the use of alcohol by drivers and pedestrians leads to some 25,000 deaths in a total of at least 800,000 crashes in the United States each year."

Equally significant is the estimate that over half of those 25,000 fatalities involved alcoholics or problem drinkers.

These figures are everybody's concern, whether he be driver, rider, or merely a pedestrian crossing a public street or highway.

They are the concern of alcoholism counselors, too. Many of their patients are grounded drivers making a show of treatment in order to get their suspended or revoked operator licenses reinstated. But beyond that, alcoholism counselors are certain to be more and more involved in new preventive measures being urged by an aroused public.

The basic question is, "Who is the drunken driver?" In the old days they used to test the suspect by having him walk a straight chalk line. But many a drinking driver could walk from here to infinity without a hitch, and yet his reaction time was so slowed and his judgment so impaired that he had no business behind a steering wheel in his own driveway.

Today, more scientific procedures prevail. It is recognized that the degree of intoxication can be measured by the concentration of alcohol in the blood stream. (See Chapter I, "Physiological Effects.") In the same 1968 report to Congress, the Department of Transportation observed: "The higher a driver's blood alcohol concentration, the disproportionately greater is the likelihood he will crash; the greater is the likelihood that he himself will have initiated any crash in which he is involved; and the greater is the likelihood that the crash will have been severe."

The National Highway Safety Bureau regards a concentration of .10 per cent or higher as indicative of a state of intoxication, or drunkenness, at which point the driver becomes menace to everybody's safety, including his own. (Many states still legally recognize a .10 per cent concentration as "impaired," .15 per cent as "intoxicated.")

The degree of alcohol concentration may readily be determined by blood, breath or urine tests. To be reliable and admissible as evidence in courts, the tests must be started within two hours of the time of any related accident or alleged violation of the law. Blood and urine tests require laboratory analyses. Breathalyzer tests give the answer on the spot.

With such dependable checks at our disposal -- especially the breathalyzer -- why are offenders not gotten off and kept off the highways?

First, most states have no provision for the police to restrain a driver before he has actually broken a law. Even then, if the infraction is a minor one, many officers are reluctant to be a party to the possibility of the driver's losing his license. His car, or his ability to drive, may be his source of livelihood. So an arrest could also lead to a loss of gainful employment with all its painful repercussions.

Such reluctance is not limited to police officers. When a person accused of drunken driving is brought before the court, many jurors and some judges cannot help but reflect as they look upon him, "There, but for the grace of God, am I." All too frequently the result is an aequittal or a hung jury. Unless the evidence is overwhelming, it is often difficult for the prosecution to obtain a verdict of guilty.

The obvious way to reduce the weight of human misjudgment in such cases is to introduce the irrefutable evidence of blood, breath or urine tests. But some states have no chemical test laws and others no adequate definition of what constitutes intoxication. Even where there are appropriate laws, sufficient equipment and trained persons to operate it are frequently unavailable.

Also, unless a state has an "implied consent" proviso in its traffic laws, the intoxicated motorist can refuse to submit to a chemical test until he can secure the advice of counsel. Then his lawyer may see to it that he does not arrive at the scene of the accident or the police station where his client has been detained until it is too late to make a valid test.

This and similar evasions are forestalled when there is an "implied consent" law. This means that when a driver accepts a license to operate a motor vehicle, he is deemed to have agreed to submit to a blood, breath or urine test if he is ever arrested on a charge of driving while intoxicated. If he refuses to submit, it can mean the suspension of his license, regardless of any other court action in connection with the charges.

Recently, some states have gone so far as to require applicants for new licenses or renewals to sign an "actual consent" statement agreeing to submit to such tests, with suspension of the license the penalty for failing to do so.

Even when adjudged guilty of driving while intoxicated, the penalties may be ineffective. Fear of the loss of his driving privileges may deter the "social drinker" drom driving while drinking. But not many alcoholics. The fear of penalties usually evaporates after the first drink. Although their licenses have been suspended or revoked, they are apt to continue driving. A study recently made in one state indicated that two-thirds of all drivers with revoked permits were arrested, some as many as ten times. In that state, as well as in many others, the failure has been to take practical steps to enforce its own imposed penalties.

One other shortcoming is the lack of compulsory treatment programs. An alcoholic may be arrested for the first time and his operator's license suspended for thirty, sixty, or ninety days. During that period he makes no effort to seek treatment for his illness. Instead, he continues drinking to while away the grounding and, at the end, he is even more of a menace on the highways than he was before.

Better he be required to seek clinical treatment, attend A.A. meetings, or undergo some other reliable form of therapy. (Because of the anonymity observed, it is difficult to verify his attendance at A.A. meetings.) But such measures are the exception rather than the rule.

To meet some of these shortcomings, the National Highway Safety Bureau has proposed a "Standard:"

Each state, in cooperation with its political subdivisions, shall develop and implement a program to achieve a reduction in those traffic accidents arising in whole or in part from persons driving under the influence of alcohol. The program shall provide at least that

I. There is a specification by the state of the following with respect to alcohol-related offenses:

   A. Chemical test procedures for determining blood-alcohol concentrations.

   B. (1) The blood-alcohol concentrations, not higher than 0.10% by weight, which define the terms, "intoxicated" or "under the influence of alcohol," and

      (2) A provision making it either unlawful, or presumptive evidence of illegality, if the blood-alcohol concentration of a driver equals or exceeds the limit so established.

II. Any Person placed under arrest for operating a motor vehicle while intoxicated or under the influence of alcohol is deemed to have given his consent to a chemical test of his blood, breath, or urine for the purpose of determining the alcohol content of his blood.

III. To the extent practicable, there are quantitive tests for alcohol:

   A. On the bodies of all drivers and adult pedestrians who die within four hours of a traffic accident.

B. On all surviving drivers in accidents fatal to others.

IV. There are appropriate precedures established by the state for specifying:

A. The qualifications of personnel who administer chemical tests used to determine blood, breath, and other body alcohol concentrations.

B. The methods and related details of specimen selection, collection, handling and analysis.

C. The reporting and tabulation of results.

V. The program shall be periodically evaluated by the state, and the National Highway Safety Bureau shall be provided with an evaluation summary.

Neither this "Standard" nor any others proposed by the National Highway Safety Bureau can become a part of the laws of any state unless the state itself acts through its legislature to make them laws. And it takes public education and manifest public opinion to expedite that.

There is much to be done to reduce the slaughter caused by drunken driving. The U.S. Department of Transportation is giving it top priority, with many studies now being conducted in various sections of the country.

One of the major considerations is that of treatment for the alcoholic driver. And this is where alcoholism counselors will play a major role.

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CHAPTER VIII

ALCOHOLISM IN INDUSTRY

Alcoholism costs American business and industry over $4 billion a year in lowered efficiency and loss of time. Businessmen and industrialists are becoming increasingly aware of this, and more and more of them are facing up to the problem in constructive ways.

Problem drinkers are to be found on every level of the industrial hierarchy, especially between the ages of 35 and 50, the most productive years. Estimates of the frequency of alcoholism among workers at various plants across the nation vary, but the generally accepted average is about five per cent. When one considers that the alcoholic worker costs his company about a quarter of his wages in inefficiency, accidents, and absenteeism, the $4 billion might well be an underestimation.

THE HIDDEN ALCOHOLIC

For years it had been an old American custom to regard an employee's drinking habits as his own private business until his overindulgence seriously interferred with his job performance and could no longer be tolerated.

This put an enormous premium on concealment of the problem. By suffering in silence -- and often covered up for by a supervisor -- the practicing alcoholic could manage not only to stay on the payroll and collect fringe benefits, but also to remain eligible for promotion. When unable to report for work because of intoxication or withdrawal symptoms, he would successfully allege gastritis, upper respiratory infection, or some other "respectable" ailment and draw sick leave pay. Even when he did report on a "morning after," he was there in body but not in mind. He was only half a man and his performance suffered accordingly.

Thus, the disease was allowed to progress to a moment of truth, a point of no return. The employee would summarily lose his job and the company would lose its investment in his recruitment, placement and training.

With a growing recognition of alcoholism as a progressive disease, many administrators began to probe more deeply into sickness, absenteeism and other costly personnel matters. They had been accepting "problem employees" as inevitable members of the company family. Now they discovered that a high percentage of those with undue illnesses, unexcused absences, accidents and disciplinary actions also had drinking problems. To promptly weed them out of their organizations would mean forfeiting untold sums of money in experience and know-how, plus the cost of training replacements.

Certain farsighted executives reasoned that the best solution was to help their alcoholic employees recover from their illness, rather than arbitrarily punish them. In 1943, the first formal rehabilitation program was introduced into a major, multiplant corporation in the United States. By 1959, there were about fifty formal programs and by the end of 1969, there were over 1,000 with the number growing.

The reasoning proved correct. For example, one large manufacturer of electrical products found that the absentee rate attributed to alcoholism dropped from 8 to 3 per cent, and the discharge rate of problem drinkers from 95 to 8 per cent. They estimated that they saved $80,000 a year as a result of their problem.(1)

BASICS OF A COMPANY PROGRAM

What is sauce for the goose is not necessarily sauce for the grouse or the guinea hen -- any more than one company's alcoholism program is good for a company on the other side of town. It must be tailored to fit the organizational structure.

But there are elements that are common to most of the company programs now being successfully used throughout the country.

First, and most important, is to remove the social stigma that folkways and prejudice have attached to alcoholism. Employees must be made to realize that alcoholism is an illness, and is so regarded by management. That anyone suffering from the disease will never be disciplined merely because he is an alcoholic. That his drinking is her personal business until it affects his work performance, and only then does it become the company's business.

This removal of the stigma is the most critical, and often the most difficult part of the program. It has become deeply embeded by the conspiracy of silence and concealment which has prevailed for many generations. The average worker is usually grateful for the company's concern with his health. Even if he is an alcoholic, he willingly submits to an examination of his heart and lungs. But let the doctor ask about his drinking habits and he freezes up.

The most effective counterstep is the power of example -- i.e., for management to treat alcoholic employees as sick persons, not as moral weaklings or troublmakers. The organization's grapevine will quickly spread the word. A simple educational program about the nature of the disease can supplement the down-to-earth examples.

Also imperative is that immediate supervisors recognize the symptoms of alcoholism, especially in its early stages and then know what steps to take. The supervisors must be made to realize that the precedures are no part of any "witch hunt," but a move towards saving a worker for the company and for his own sake.

Once an employees has definitely been identified as an alcoholic, he is given a choice between accepting treatment with the company's continued support, or refusing treatment and risking disciplinary action if his work performance continues unsatisfactory.

This is known as "constructive coercion" and is not as unilaterally harsh as it may sound.

Few alcoholics are able to arrest their illness until they are willing to accept treatment. More often than not, it takes a crisis to evoke willingness. And management has the ways and means of creating that crisis -- by putting an alcoholic worker's job at stake.

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(1) Allis-Chalmers Corporation

This may prove a blessing not only to him but to all concerned with his well-being. He must understand that by responding to therapy he will continue in, or re-enter, his role as a part of the corporate family. While he will always be vulnerable to the effects of alcohol, he need not wear the label of an inebriate. So far as the company is concerned, that label will, with continuing sobriety, be removed.

These bare essentials of a company program should be clearly defined in a policy statement which has management's solid support. They should be rounded out by an explanation of procedures to be employed, from the detection of early symptoms through treatment and follow-up.

IMPLEMENTING THE PROGRAM

In planning an industrial alcoholism program, it is important to involve from the very beginning all interested parties from both management and labor. The company's team should include key executives, representatives from the medical and personnel departments, and supervisory personnel. Labor should be represented by union executives and shop stewards. This approach generally provides for a clear understanding of the goals of the program. It can result in an atmosphere of mutual trust and respect -- at least in matters pertaining to alcoholism.

In this way, workability and flexibility are most apt to be achieved from the very start and many later grievances forestalled. The essentials of the program will have been approved by management and labor alike. They are ready to be put into practice. The time is then ripe for widest possible circulation, not only through the potent company grapevine, but in such other media that may be available -- e.g., house organs, newsletters, etc.

A new alcoholism program, just as any other innovation, is bound to meet resistance. The war between "Wets" and "Drys" has been raging for too many years not to have left prejedices, and these cannot be uprooted overnight. But in the case of an industrial or business hierarchy, management has the privilege of determining its own basic policies.

So while it might be more encouraging to top executives if all immediate supervisors were in full accord, that is most unlikely. The usual practice is to instruct the dissenting supervisor to leave his prejudices at home or at least outside the premises, and to follow the new procedures as directed. Hopefully the results will tend to change his way of thinking.

THE IMMEDIATE SUPERVISOR

Outside of the alcoholic employee himself, the key man in any alcoholism program is his immediate supervisor. He is often a key person in the worker's personal life as well -- even more than his wife, children, or parents.

With this relationship, it is understandable how a supervisor can be ambivalent in his feelings. On the one hand, he realizes that the alcoholic's lowered efficiency is interfering with production, for which he is accountable. On the other hand, he does not want to report it and be responsible for a man's loss of his job. And should he have more than one alcoholic on his crew, he fears that knowledge of it will reflect on his ability as a leader and perhaps cost him his own job.

With management's endorsement of a policy that recognizes alcoholism as a disease, some of this uncertainty can be dispelled. But it is also imperative that management make clear that it will support him in any necessary action taken to refer the worker to the company's rehabilitation program.

Since it is important to both the company and the man that treatment begin as soon as possible, the supervisor must be aware of the symptoms. While alcoholics are generally considered to be experts in covering up the telltale signs of their infirmity, it is doubtful that they are very successful after the initial phase, particularly to a supervisor who is thrown into close, daily contact with him.

Following are some of the symptoms that have been noted by management, supervisors, and recovered alcoholic workers:

Chronic absenteeism -- Half days or full days, particularly following weekends or days off. (Absenteeism is probably the one inescapable clue motivating most companies to consider alcoholism programs.)

Change in behavior -- The moody individual who suddenly becomes exuberant, or the sociable one who becomes a loner. The former is often an indication of lunchtime drinking.

Physical signs -- Red or bleary eyes, uncommonly flushed face, chronic hangovers, hand tremors.

Spasmodic work pace -- Veteran alcoholics may deliberately slow down while under the influence of alcohol in an effort to avoid accidents.

Lower quality and quantity of work -- This can be especially evident after lunchtime drinking.

Partial absences -- The employee leaves his work area with greater frequency -- either to "pull himself together" or to "have a quick one."

Lying -- Usually begins with improbable excuses for absences; then extends to all phases of his worsening performance.

Avoiding supervisor and co-workers -- To avoid detection of on-the-job drinking or of other symptoms that the worker can no longer hide.

Although recognizing alcoholism is a responsibility of the supervisor, he is not a doctor. He cannot and should not tell any worker that he is an alcoholic. All he can and should do is "to level with" the ailing employee. He can point out shortcomings in his behavior and performance on the job. He can suggest the possibility that they could be related to some health problem, and then insist that the worker be examined by the company physician.

Nor is the supervisor expected to counsel the employee. At best, he would be "moralizing -- preaching." Most alcoholics have had so much of this from their family and friends that they have become past masters at manipulating, maneuvering, and controlling any confrontation. It is useless for the supervisor, day-in-and-day-out associate that he is, to try to do the same.

The supervisor's duty to the company and to the employee is to spot the symptoms with growing job impairment, and then refer the man to those whose responsibility it is to follow through. It may be to the personnel department, to the medical department, to an alcoholism counselor on the organization's staff, depending upon established procedures.

The supervisor can help to motivate the worker in complying with the program and there saving his job. The earlier this is accomplished, the better the chances for a happy ending.

TREATMENT

The company's physician or medical department must make the critical diagnosis. Justified or not, some workers are wary of entrusting very intimate problems to their company's medical personnel. They view them as management's watchdogs against health and accident claims. So while the doctor is responsible for evaluating the symptoms and even for recommending treatment to avert possible dismissal, it should not be up to him to actually apply constructive coercion. "Final warnings" and termination of employment are functions of the personnel department or whomever management may designate.

However, once the worker is diagnosed as an alcoholic, it is the physician's responsibility to refer him to treatment facilities within the organization or on the outside.

The company should enlist the cooperation of resources in the surrounding community before the program is introduced to employees as a new blueprint for action. In an ideal setup these would include, among other social agencies, hospital inpatient and outpatient services, clinics for psychotherapy, Alcoholics Anonymous, and Al-Anon for families of alcoholics. Unfortunately, all of these are seldom available except in cities, and some facilities still balk at treating alcoholics.

A large corporation in a smaller community can bring its prestige to bear in improving such conditions. Smaller organizations can unite in their efforts. And where union workers are involved, the union itself may add its weight to bring about community understanding and action. In larger cities, some unions maintain their own facilities for treatment of their members.

Alcoholics Anonymous groups call for no professional supervision, are concerned solely with achieving and maintaining sobriety, and are, therefore, found all over the map. One corporation sponsors A.A. meetings on its premises. Another allows time off to attend outside meetings. Others depend upon their alcoholic charges to attend regularly scheduled meetings on their own initiative.

The responsibility for referring employees to such facilities will vary according to the organizational structure and the attitudes of those holding the executive reins. The company's physician usually makes the initial referral. After that, they may find it best to hire an industrial consultant -- as a staff member of free lance -- to provide continuing counseling and assistance. They might even assign it to a recovered executive who has been through the mill to turn his own experience to good account, "in addition to other duties."

Whatever the modus operandi, the target is recovery. And to industrial employers, "recovery" means that the employee is once again doing a satisfactory job. He may have lapses. But if his attendance, his work performance, and his general health continue good, they feel that the primary goal has been attained.

Many companies follow-up by having alcoholic employees periodically examined by their medical departments for as long as five years after initial recovery.

"SMALL PLANT" PROGRAMS

Alcoholism programs for smaller plants and businesses are basically the same as described above. However, they do not usually have the organizational setups and personnel to follow through on procedures in quite the same way.

In many communities, the National Council on Alcoholism has local information centers which cooperate in developing programs for industries of all sorts and sizes.

A common practice is for a number of plants or business concerns to join forces and establish a clinic of their own. Medical doctors and psychiatrists in the area are approached for advice and possible participation in the services offered by the clinic. Local medical societies can be particularly helpful in this regard.

Another means towards the same end is for a large organization to allow smaller organizations to share its facilities. In 1952, Consolidated Edison of New York underwrote the costs of establishing an alcoholism consultation center in University Hospital. Other firms were invited to make use of the installation. By the time a foundation took over its sponsorship, twenty concerns were referring their workers to it on a fee-for-service basis.

Whatever method may be chosen, each plant or business should have its own program coordinator. He should be a good organizer. His office serves as an information center for all phases of alcoholism, a clearing house for referrals to community resources, and as liaison with part-time doctors serving the company. He works closely with supervisors and, if possible, conducts periodic orientation meetings to cope with the problems and questions that inevitably arise.

In smaller communities a supervisor or coordinator may pick up additional clues to supplement the on-the-job symptoms. He may hear of one of his worker's excessive drinking in public places followed by a partiality for drinking alone, evidence of growing family and financial problems, frequent brushes with the law. Such observations or knowledge may call for no immediate action -- unless his job performance is suffering -- but they are signals for the supervisor to be on the alert.

LABOR UNION COOPERATION

In developing a new alcoholism program, management will do well to involve any labor unions from the very outset. This may be an informal or a formal invitation to participate. The union must be convinced that the program is a constructive and not a punitive one.

At the same time, management should appreciate the union representative's point of view. The latter is elected and paid by the workers to secure their jobs. He knows that many of them find pleasure in drinking, that the local tavern is often called "the workingman's club." That they and their families use alcohol to enliven many a social get-together.

In the past, he feared their possible reaction once they suspected that he was party to a company's new alcoholism program. He imagined their grumbling, "My drinking is my business. I'm paying him dues to protect my job, not interfere with my personal life."

So he felt it a matter of political expediency to oppose the program, instead of looking ahead to the ultimate disaster which may await the alcoholic worker and even cost him his life.

Such was yesterday's pattern. Today many unions view alcoholism as the serious illness it is and willingly cooperate with management in seeking to control it. Typical is the United Steelworkers of America contract: "Without detracting from the existing rights and obligations of the parties recognized in the other provisions of this agreement, the Company and the Union agree to cooperate at the plant level in encouraging employees afflicted with alcoholism to undergo a coordinated program directed to the objective of their rehabilitation."

The climate should be right. Union and management should not be at loggerheads over other matters at the time the new alcoholism program is introduced. If there is tension in the overall relationship, it will seriously interfere with the cooperation always necessary in dealing with alcoholism.

The public attitude towards alcoholism, both in the plant and in the community outside, should be one of understanding. If not, both sides should be willing to unite in striving to remove the stigma through public education. This joint effort should extend to insuring the availability of community resources for the treatment of alcoholic employees. Representatives of both should serve on boards and committees of local health and social agencies.

Union shop stewards, like supervisors, should be aware of the symptoms of alcoholism, particularly in the early stages. Both enjoy the same close relationship with the workers. If a shop steward were not close to his men, he would soon lose his job.

The union member, as observed above, looks upon his union as a protective agency. Should he run up against his company's enlightened alcoholism policy, be told to seek treatment, rebel and then be told the same thing by his union, he finds he cannot play off the one against the other. He will no doubt reconsider and more willingly accept the treatment offered.

Such is the value of union and management's working together, preferably from the very start.

Any program directed towards the rehabilitation of the alcoholic cannot be said to be pro-management or pro-labor. It is pro-human and must be sold as such to both executives and the rank-and-file.

For the alcoholism counselor, this field is a challenging one. With company programs proving 50 to 75 per cent successful, it is a satisfying one as well.

SUPPLEMENTAL READING

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National Council on Alcoholism pamphlets and reprints:

AFL-CIO, "What Every Worker Should Know About Alcoholism"
Carney, John D., "Some Realities of a Joint Management-Labor Alcoholism Program"
Greathouse, Pat, "The Union and the Problem Drinker"
Hamilton, Andrew, "Business and the Compulsive Drinker"
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CHAPTER IX

TEENAGERS AND ALCOHOL

From time to time the alcoholism counselor is called upon to discuss the subject of alcohol and drinking with groups of young people in high school, churches and elsewhere.

Once upon a time it was the custom to pack a high school auditorium with captive boys and girls and call upon a visitng speaker to terrify them en masse with harrowing descriptions of life on Skid Row and the town drunk's gruesome journey to the grave. Perhaps this was a deterrent to some of the students' teachers who liked a nip or two after hours. But so far as the boys and girls went, they could not have cared less.

In general, teenagers are no more concerned with the possibility of becoming alcoholics a couple of decades hence than they are with old age pensions or Medicare. Those are bridges to be crossed when they get to them.

But they are interested in alcohol and intoxication. Those are matters that sometimes crop up in their very midst -- today. If a teenager has not experimented with alcohol himself, he has seen classmates experiment and has observed the effects. It gives him pause to reflect about the aftereffects -- the immediate aftereffects.

THE NEED TO ADAPT

The late Dr. Raymond G. McCarthy of the Yale Center of Alcohol Studies used to cite a poll of 582 high school students and their most popular questions about drinking.

Among boys the questions were, in order of frequency: "Will drinking hurt my athletics?"; "Will girls do what I want if they are drinking?"; "Is whiskey more harmful than beer?"; "Will I become a drunkard?"; "Why is drinking permitted?"; "Will drinking cause diseases?"; "Can I do more work if I drink?"; and "Does drinking increase my sexual powers?"

Among girls the most recurrent questions were: "Will drinking make me fat?"; "Will the boys like me as much if I drink?"; "I don't wish to know anything"; "Is whiskey more harmful than beer?"; "Will drinking cause diseases?"; "Why do people drink?"; "Why is drinking allowed?"; and "How can I know when to stop before I get drunk?"

Such questions would, of course, vary according to the times, the environment, and other social factors. But they have one thing in common-- immediate effects. (Even the inquiries about disease and obesity can be considered as being of immediate concern, as against questions which trouble the addict about the eventual effects of his continued drinking.)

So although prepared to answer questions about the progress of untreated alcoholism to its tragic finale, the counselor had better emphasize pre-addictive behavior in addressing himself to teenage groups. This would include exploding the various myths and misconceptions regarding drinking (Chapter I, "Alcohol, the Beverage"). Otherwise his words may fall on deaf ears.

Teenagers will be attentive if he speaks convincingly about automobiles, driving and highway safety (Chapter VII). He can stress that alcohol and gasoline are a deadly combination, tying it in with recent, local traffic fatalities. He can point out that even one arrest for driving while intoxicated is permanently recorded in police records. It is a lifelong black mark to haunt one in any future arrests or license applications in every state in the Union.

Teenagers will listen when the counselor speaks of alcohol and promiscuous sex. He can describe how even the first drink impairs judgment and inhibitions (Chapter I, "Alcohol, the Beverage.") A resultant sexual abandon can lead to a dismaying pregnancy, a costly abortion, and/or an unfortunate marriage -- a high price for a few minutes' inept fun.

Nor should the counselor fail to mention that the intoxicated "life of the party" is seldom the card he believes himself to be. His unpredictable, raucous behavior soon irritates the other guests. They go out of their way to avoid him. If he persists, his antics frequently culminate in fights. And before long his name is dropped from invitation lists. He has earmarked himself as a nuisance.

It should be pointed out that such misfortunes are not necessarily limited to alcoholics or excessive drinkers. Like many other aberrations in behavior -- including anti-social acts impulsively committed while in one's cups -- they are the result of the same impairment of judgment that starts with the first drink.

The alcoholism counselor should keep in mind that drinking among teenagers is almost always a group affair, a gregarious social activity given added attraction because of parental or other "official" disapproval. Heavy drinking is rare. The average teenager does not turn to alcohol to escape psychological or emotional problems.

There may be one member of a group who will drink more than the others in a deliberate attempt to get "high" or even drunk -- such as the "life of the party" mentioned before. He is likely to do the same thing on every such occassion. He may very well be a potential alcoholic. But he is an "oddball," unlike most of his peers, in his drinking behavior.

PRESENTING THE FACTS

The "lecture method" of fostering alcohol education among teenagers is generally undesirable. To herd fifty to one hundred or more students into an auditorium and have a doctor, lawyer, alcoholism counselor or some other outside speaker discourse on the facets and phases of drinking is inviting apathy, boredom and inattention.

If possible, it is better to break down the large group into smaller groups or classes and encourage participation by all.

The atmosphere of free give-and-take found in successful psychotherapy groups is particularly conducive to enduring learning. The effective group leader can gently steer the discussion into any areas he wish to cover. Then by having the teenagers ask the questions he hopes they will ask, he can put across the same points he would stress from a lecture platform. In the smaller groups with open participation, the show is more the teenager's show than it is the leader's -- or so they feel. The teenager can fancy himself as both actor and director. And apathy, boredom and inattention are forestalled.

The informality of the smaller groups affords greater latitude for discussing points that teenagers are vitally interested in -- points that the platform speaker might overlook in preparing his talk. It also affords group leaders an opportunity to suggest the eventual hazards of uncontrolled drinking. At the beginning of this chapter it was observed that the teenager is concerned with intoxication and its immediate effects, not with the possibility of becoming an alcoholic some decades hence. Nevertheless he should be made aware of it. By a remark here, an illustrative comment there, the leader can implant the ultimate dangers in the teenager's mind without making a production of it.

Should the alcoholism counselor find himself delegated to procure group leaders or platform speakers, if necessary, he should make sure that they are emotionally unbiased. This is particularly true in dealing with alcohol and alcoholic rehabilitation. In almost any community there is apt to be the opinionated member of Alcoholics Anonymous who attained his own sobriety through that fellowship and who will not accept the validity of any other recovery program. At the same time there is the professional worker who refuses to acknowledge the therapeutic power of spiritual surrender. Such extremists are to be avoided. Tolerance and understanding are essential.

Care must also be exercised in selecting members of the "teaching staff" that their knowledge of the subject be unquestionable. Otherwise well-informed teachers and authors have been guilty of widely circulated misstatements and misconceptions about alcohol and alcoholism -- over and beyond those cited before (Chapter I, "Alcohol, the Beverage"). Typical are:

Equating alcoholism with Skid Row -- whereas only 5% of all alcoholics are social and economic down-and-outers.

That alcoholism is a basic cause of personal, family and social disintegration -- whereas excessive drinking is only a symptom of a personality disorder. It is the latter that contributes to the disintegration.

That alcohol is always a poison or narcotic -- whereas it is a sedative in small quantities.

That alcohol always destroys or damages organic tissues. This is untrue in any concentration the body can tolerate.

Above all, the man or woman who thinks any and all drinking is "wrong" and says so, should have no place in the teenagers' classroom. Teenagers are not stupid. They know that a majority of Americans drink. They only have to look at the men and women around them to know that all but a small percentage do so without getting into trouble. To tell teenagers that any and all drinking is "wrong" is to insult their intelligence. It can threaten the credibility of anything else that may be said.

Finally, there is a disposition today to lump alcohol addiction and drug addiction together and serve them up as one subject for teenage consumption. This can be confusing. Admittedly both are addictions with unfortunate end results. But there are many differences between them -- medical, legal, social, cultural, religious, etc.

To deal with them at the same time in the same group or class can be disconcerting to teenager and teacher alike. It is better to consider them separately. If that is not possible, study the differences first, and then gear the discussion accordingly.

SUPPLEMENTAL READING

Teenagers and Alcohol

Atkins, A.J. and Gwynn, J. Minor, "Teaching Alcoholism Education in the Schools," Macmillan

Bacon, Margaret and Jones, Mary B., "Teenage Drinking," Crowell

Maddox, George L. and McCall, B.C., "Drinking Among Teenagers," Rutgers University

McCarthy, Raymond G., "Teenagers and Alcohol," Yale University

McCarthy, Raymond G., "Alcohol Education for Classroom and Community," McGraw Hill

Todd, Frances, "Teaching About Alcohol," McGraw Hill

National Council on Alcoholism pamphlets and reprints:

Block, Jean L., "Alcohol and the Adolescent"
Lee, John Park, "What Shall We Tell Our Children About Drinking?"
McCarthy, Raymond G., "Discussion Guides for Questions about Alcohol" (set of 3)
Oppenheim, Garrett, "When Your Teenager Starts Drinking"
Smith, A.J., "What I'd Teach My Children about Alcohol"